FLORIDA GULF COAST UNIVERSITY
STUDENT HEALTH SERVICES

Phone: (239) 590-7966
Fax: (239) 590-7968

Medical History

Name:______________________________________ FGCU ID #__________________________
(Last, First, Middle)

Date of Birth:_____/_____/_____ Age:________ Gender:________ E-mail:______________________________

Cell Phone:(________)____________________ Home Phone:(_______)____________________

Local Address:____
(Street) (City) (State) (Zip)

Permanent Address:____
(Street) (City) (State) (Zip)

Person to notify in case of emergency:__________________________Relationship to you:____________________

Phone: (______)____________________ Address:____
(Street) (City) (State) (Zip)

FAMILY HISTORY (Parents, Siblings, Grandparents) *Check where applicable*

- ☐ Alcoholism
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Disorder
- ☐ Cancer
- ☐ Convulsions
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Mental Illness
- ☐ Migraines
- ☐ Sickle Cell
- ☐ Stroke
- ☐ Sudden Death
- ☐ Tuberculosis
- ☐ Other (Specify) ______________________

PERSONAL HISTORY *check where applicable*

- ☐ Arthritis
- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anxiety
- ☐ Asthma
- ☐ Bladder/Kidney Infection
- ☐ Blood Disorder
- ☐ Cancer
- ☐ Cardiac Abnormalities
- ☐ Chronic Cough
- ☐ Chronic Kidney Disease
- ☐ Congenital Anomaly
- ☐ Constipation
- ☐ Depression
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Eating Disorder
- ☐ Emotional
- ☐ Fainting/Dizziness
- ☐ Frequent Colds
- ☐ Gastrointestinal Problems
- ☐ Headache
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hypertension/ High Blood Pressure
- ☐ Insomnia
- ☐ Mental Illness
- ☐ Migraines
- ☐ Obesity
- ☐ Rheumatoid Disease
- ☐ Seasonal Allergies
- ☐ Seizures/Epilepsy
- ☐ Sickle Cell
- ☐ STD
- ☐ Thyroid Disease
- ☐ Tuberculosis

Are you under treatment for any medical/emotional condition? *(describe)*:______________________________________

Past surgeries (*describe*):____

Past serious illness/injury (*describe*):____

ALLERGIES *check where applicable*

- ☐ No Known Drug Allergies
- ☐ Aspirin
- ☐ Penicillin
- ☐ Codeine
- ☐ Sulfa
- ☐ Name of other drug:__________________________
- Reaction to drug:______________________________
- ☐ Latex
- ☐ Food
- ☐ Animal
- ☐ Insect
- ☐ Other (please specify)____________________

MEDICATIONS *check where applicable*

- ☐ None
- ☐ Over the Counter_________________________________
- ☐ Oral Contraceptives______________________________
- ☐ Vitamins_______________________________________
- ☐ Herbal____
- ☐ Prescription____________________________________
- ☐ Illicit Drugs____________________________________
- ☐ Other____

INSURANCE INFORMATION

Do you have medical insurance? ☐ Yes ☐ No If yes, Name of company:____________________________________

Reason for today's visit:____

Permission is hereby granted for the FGCU Student Health Services professionals and staff to carry out indicated medical or surgical treatments. Cases requiring specialized and/or emergency care will be referred to an appropriate medical setting or professional.

Signature of Student / Parent or Legal Guardian (if minor):

____

Date:____