Today's Date: __________________

UNIVERSITY OF NEVADA, RENO
STUDENT HEALTH CENTER

Student ID#: __________________

Confidential Health Information Form — Please Print (in ink)

Name:______________________________ Birthdate: ______________ Sex: ❑ Male ❑ Female

Race: ❑ Caucasian ❑ Black ❑ Hispanic ❑ Asian ❑ Other_____ E-mail ____________________

Local Phone: ____________________ Work Phone:____________________ Cell Phone ____________________

Local Address: ____
City State Zip

Permanent Address:____
City State Zip

What medications are you presently and/or regularly taking? (including herbal remedies & supplements) ____________________

____

What medications are you allergic to? ____

What other allergies do you have? ____

TO THE BEST OF YOUR KNOWLEDGE, HAVE YOU EVER HAD OR BEEN TOLD YOU HAVE HAD:
(circle condition and explain.)

	YES	NO	*GIVE DETAILS OF ALL "YES" ANSWERS*
A. Seizures, fainting spells, migraines, paralysis, or any disease or abnormality of the brain or nervous system?			
B. Heart attack, murmur, palpitation, high blood pressure, rheumatic fever, or any disease or abnormality of the heart, blood or blood vessels?			
C. Tuberculosis, asthma, pleurisy, or any disease or abnormality of the lungs, bronchial tubes, ear, nose, throat or respiratory system?			
D. Ulcer, indigestion, colitis, blood in stool, gallstone, hernia, or any disease or abnormality of the stomach, intestines, rectum, gallbladder or liver?			
E. Urinary problems, sexually transmitted diseases, abnormal pap smears, irregular periods, or any disease or abnormality of the breasts, kidneys, prostate, or genital system?			
F. Diabetes, or any disease or abnormality of the thyroid or other glands?			
G. Arthritis, rheumatic fever, back trouble, or any disease or abnormality of the joints, muscles or bones?			
H. Any disease or abnormality of the eyes or skin?			
I. Cancer or tumor?			
J. Any physical deformity or defect?			
K. Any surgical operations or pregnancies?			
L. Any weight or nutrition problems, dietary restrictions, or history of eating disorders?			
M. Depression, anxiety, or other psychiatric problems?			
N. Any other medical problems?			

SOCIAL HISTORY

1. Do you use tobacco (smoke, chew, hookah)? ❑ Yes ❑ No If yes, what type, how much? ____________________
2. Do you use alcohol? ❑ Yes ❑ No If yes, how much per week? ____________________
3. Do you use drugs? ❑ Yes ❑ No If yes, what type and how often? ____________________
4. Have you, or any of your sexual partners, ever had a blood transfusion or history of IV drug use (even once)?
   ❑ Yes ❑ No If yes, explain______________________________

ANY FAMILY HISTORY OF THE FOLLOWING:

Diabetes?..	❑ Yes	❑ No	If Yes, who? ________________________
High blood pressure?...................................	❑ Yes	❑ No	If Yes, who? ________________________
High cholesterol?..	❑ Yes	❑ No	If Yes, who? ________________________
Migraine headaches?....................................	❑ Yes	❑ No	If Yes, who? ________________________
Thyroid disease?...	❑ Yes	❑ No	If Yes, who? ________________________
Kidney disease?..	❑ Yes	❑ No	If Yes, who? ________________________
Asthma?...	❑ Yes	❑ No	If Yes, who? ________________________
Addiction?...	❑ Yes	❑ No	If Yes, who? ________________________
Mental illness?..	❑ Yes	❑ No	If Yes, who? ________________________
Bleeding disorder?..	❑ Yes	❑ No	If Yes, who? ________________________
Blood clots?...	❑ Yes	❑ No	If Yes, who? ________________________
Heart attack?...	❑ Yes	❑ No	If Yes, who? ________________________
Stroke?..	❑ Yes	❑ No	If Yes, who? ________________________
Cancer?...	❑ Yes	❑ No	If Yes, who? ________________________
Other family illness?....................................	❑ Yes	❑ No	If Yes, who? ________________________

IN CASE OF EMERGENCY NOTIFY: ❑ Parent ❑ Guardian ❑ Spouse ❑ Friend ❑ Other

Name:____ Home Phone: ____________________

Address:____

City State Zip

Release of Information

* The medical record is privileged communication, therefore there shall be no release of information to any person or agency without my written authorization unless required by law. If I have health insurance: I hereby authorize the University of Nevada, Reno Student Health Center to release any information necessary to process my insurance claims. I will not hold the University of Nevada, Reno Student Health Center or the University liable for any release made in good faith to my insurance company. In case of referral to another health care provider or admission to a hospital, I agree that my medical records can be sent without an additional medical record release.

* I hereby authorize the University of Nevada, Reno Student Health Center to provide, at my request, all ordinary examinations and medical treatment, as well as any necessary emergency care. The University of Nevada, Reno Student Health Center is a teaching institution. For this reason, residents, medical students, physician assistant students, and nurse practitioner students may participate in my care under the supervision of a physician, physician assistant or nurse practitioner. I am to be notified and give my consent to be seen by said personnel while they are working at the University of Nevada, Reno Student Health Center.

Signature of patient:____ Date: ________________

Reviewed by: ____ Date: ________________