

University Health Services

P. O. Box 2054 • Nicholls State University
Thibodaux, LA 70310

Medical Questionnaire

To the student: Please complete this form and return it to University Health Services, Student Union building. The information you provide will be used solely as an aid to providing the necessary health care while you are a student. This information is confidential.

Your Last Name	First Name	Middle	Social Security No.	Date of Birth
Home Address (Street and Number)			City or Town	Zip Code
Name, Relationship and Address of Parent/Guardian/Spouse or Emergency Contact			City	Phone Number
Parent or Guardian's Business Address			City	Phone Number

Have any of your blood relatives had: Yes No	Have any of your blood relatives had: Yes No
(Blood relative - parents, grandparents, brothers or sisters)	
Tuberculosis? _____ _____	Cancer? _____ _____
Diabetes? _____ _____	Arthritis? _____ _____
Kidney Disease? _____ _____	Asthma/Hay Fever? _____ _____
Heart Disease or _____ _____	Seizures/Convulsions? _____ _____
High Blood Pressure? _____ _____	Stomach, Intestinal Trouble? _____ _____

Personal History – Please answer all questions with a check.

Have you had?	Yes	No		Yes	No		Yes	No		Yes	No
Scarlet Fever			Sleeplessness			Pain/Pressure in Chest			Gallbladder Disease		
Measles			Frequent Anxiety			Chronic Cough			Recurrent Diarrhea		
German Measles			Frequent Depression			Palpitations (Heart)			Rupture, Hernia		
Mumps			Worry or Nervousness			High or Low Blood Pressure			Recent Gain/Loss of Weight		
Chicken Pox			Recurrent Headache			Rheumatic Fever or Heart Murmur			Dizziness/Fainting		
Malaria			Recurrent Colds			Disease of Injury of Joints			Weakness/Paralysis		
Gum or Tooth Trouble			Head Injury with Unconsciousness			*Trick Knee, Shoulder, etc.			Venereal Disease		
Sinusitis			Hay Fever, Asthma			Back Problems			Albumin/Sugar in Urine		
Eye Trouble			Tuberculosis			Tumor, Cancer, Cyst			Frequent Urination		
Ear, Nose, Throat Trouble			Shortness of Breath			Jaundice			Mononucleosis		
Surgery			Allergy due to			Stomach or Intestinal Trouble			Women Only		
Appendectomy			Penicillin			Seizures/Convulsions			Irregular Periods		
Tonsillectomy			Sulfonamides			Arthritis			Severe Cramps		
Hernia Repair			Serum			Diabetes			Excessive Flow		
Other			Foods (which)			Kidney Disease			Pregnancies		
			Other						Hysterectomy		
									Tubal Ligation		

Do you smoke cigarettes? <input type="radio"/> Yes <input type="radio"/> No	How many packs per day? For how long?
Do you chew tobacco? <input type="radio"/> Yes <input type="radio"/> No	How much? For how long?
Has your physical activity been limited during the past five (5) years? (Give reasons) <input type="radio"/> Yes <input type="radio"/> No	

Have you consulted or been treated by a physician within the past five (5) years? (Give reasons) Yes No

Do you have hospitalization insurance? If so, give name of company. Yes No

I declare the above information to be true and accurate; further, I hereby agree, in case of an emergency, that a physician and/or ambulance service may be called to provide any necessary medical services and that I stand responsible for the expenses of such services.

Student's Signature
J287M

Date