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, Ayo Hall. 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 | State | Zip Code | Phone Number

Name of Emergency Contact | Relationship | Home Phone Number | Mobile Phone Number

Family Physician/Primary Care Provider | City or Town | State | Phone Number

Have any of your blood relatives had: (Blood relatives - parents, grandparents, brothers or sisters)

Arthritis		Heart Disease		Stomach, Intestinal Trouble	
Asthma/Hay Fever		High Blood Pressure		Tuberculosis	
Cancer		Kidney Disease		Other (Explain)	
Diabetes		Seizures/Convulsions		Other (Explain)	

If you checked any of the above problems, please specify relationship: _____

Personal History-Please check off any diagnosis that you have had.

Albumin/Sugar in Urine		Hay Fever, Asthma		Rheumatic Fever or Heart Murmur	
Anxiety		Head Injury with Unconsciousness		Rupture, Hernia	
Arthritis		High or Low Blood Pressure		Scarlet Fever	
Back Problems		Jaundice		Seizures/Convulsions	
Chicken Pox		Kidney Disease		Shortness of Breath	
Chronic Cough		Malaria		Sinusitis	
Depression		Measles		Sleeplessness	
Diabetes		Mononucleosis		Stomach or Intestinal Trouble	
Disease of Injury of Joints		Mumps		Trick Knee, Shoulder, etc.	
Dizziness/Fainting		Pain/Pressure in Chest		Tuberculosis	
Ear, Nose, Throat Trouble		Palpitations (Heart)		Tumor, Cancer, Cyst	
Eye Trouble		Recent Gain/Loss of Weight		Urination	
Gallbladder Disease		Recurrent Colds		Venereal Disease	
German Measles		Recurrent Diarrhea		Weakness/Paralysis	
Gum or Tooth Trouble		Recurrent Headache		Worry or Nervousness	

Allergies:

Penicillin	
Sulfonamides	
Serum	
Foods (which)	
Other (Explain)	
Other (Explain)	

Surgery:

Appendectomy	
Hernia Repair	
Hysterectomy	
Tonsillectomy	
Tubal Ligation	
Other (Explain)	

Women Only

Excessive Flow	
Irregular Periods	
Pregnancies	
Severe Cramps	

Do you smoke cigarettes? ❍Yes ❍No
How many packs per day? _____
For how long? _____
Do you chew tobacco? ❍Yes ❍No
How much? _____
For how long? _____

Has your physical activity been limited during the past five (5) years? (Give reasons) ❍Yes ❍No

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

I declare the above information to be true and accurate, further, I hereby agree, in case of any 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 _____ **Date** _____

Updated Aug. 2010