Medical History Form

Student Information

Name:____ **Today's Date:**____________________

Student ID#: T________________ **Date of Birth:**________________**Gender:**______**International Student?** Y/N

Home Address:____

School Address- *Dorm & Room:*______________________________*Sums Box:*________________________________

Cell Phone Number:__________________________________ **Is it okay to leave messages on this number?** Y/N

Home Phone Number:_________________________________ **Is it okay to leave messages on this number?** Y/N

Class: ____*Freshman* ____ *Sophomore* ____*Junior* ____ *Senior* ____*Grad. Student* **Major:**_________________________

Emergency Contacts

Please list up to 3 people that we may contact in the event of an emergency

Name	Relationship	Cell Phone	Home Phone	E-mail

Medical History

Allergies: Include medications, food, insect bite/sting, or substances such as latex **No Known Allergies:** ☐

Allergy	Reaction (hives, rash, stomach pain, etc.)	Severity (mild, severe)

Current Medications: Include prescription and non-prescription, over-the-counter, vitamins, supplements, etc.

Medication	Why you take it	Dose	How often do you take it?

Personal and Family History: Have you or an immediate family member been diagnosed with any of the following?

Condition	You	Family Member	Relationship
Diabetes	Y/N	Y/N	
Asthma	Y/N	Y/N	
Tuberculosis	Y/N	Y/N	
Kidney Disease	Y/N	Y/N	
High Blood Pressure	Y/N	Y/N	
Heart Disease	Y/N	Y/N	
Stroke	Y/N	Y/N	
Thyroid Disorder	Y/N	Y/N	
Cancer	Y/N	Y/N	
Stomach or intestinal disease	Y/N	Y/N	
Bleeding Disorder	Y/N	Y/N	
Alcoholism/Substance abuse	Y/N	Y/N	
Mental Illness	Y/N	Y/N	
Other:	Y/N	Y/N	

Surgical History:

Surgery	Date of Procedure

Review of Systems

Please check any symptoms you are currently having:

Constitutional:
___Recent fevers/sweats/chills
___Unexplained weight loss/gain
___Unexplained fatigue/weakness

Eyes:
___Change in vision
___Eye pain
___Tearing/Drainage

Ears/Nose/Throat/Mouth:
___Difficulty hearing
___Ringing in ears
___Ear pain
___Runny nose/Hay fever
___Congestion/Sinus pain
___Difficulty swallowing
___Other:___________________________

Cardiovascular:
___Chest pain/Discomfort
___Palpitations/heart racing
___Excessive bleeding
___Other:___________________________

Respiratory:
___Shortness of breath
___Cough
___Wheeze
___Coughing up blood
___Other:___________________________

Breast:
___Breast lump
___Breast Pain
___Nipple Discharge
___Other:___________________________

Gastrointestinal:
___Heartburn
___Blood in Stool
___Change in bowel movements
___Nausea/Vomiting
___Diarrhea
___Stomach Pain
___Other:___________________________

Genitourinary:
___Painful urination
___Blood in Urine
___Penile or vaginal discharge
___Itching
___Low back pain or side pain
___Other:___________________________

Reproductive:
___Cramping
___Irregular menses/spotting
___Excessive flow
___Other:___________________________

Musculoskeletal:
___Muscle/Joint Pain
___Back Pain
___Limited Range of Motion
___Other:

Skin:
__Rash
___New/changing mole
___Acne
___Hair Changes/loss
___Easy bruising/bleeding
___Other:_____________________

Neurological:
___Headache
___Memory loss
___Fainting
___Seizure
___Other:_____________________

Psychological:
___Anxiety
___Depression
___Trouble sleeping
___Skipping or purging meals
___Other:_____________________

Endocrine:
___Cold/heat intolerance
___Increased thirst/urination
___Other:_____________________

Please Clarify any of the above:____

____

Is there anything you would like to add?_______________________________________

____

Substance Use:

Substance	Use?	Times Used per Week
Tobacco Type:	Y/N	
Alcohol	Y/N	
Marijuana	Y/N	
Illicit Drugs (cocaine, heroin, etc.)	Y/N	
Other:	Y/N	

I hereby authorize the University of Detroit Mercy (UDM) Wellness Center staff to provide medical treatment and service to me as they deem appropriate. This authorization will remain in effect as long as I am a student here at UDM. In the case of a minor (under age 18) a parent or legal guardian's signature below permits to the student to obtain health care in the absence of the guardian. Information obtained in care on these forms may be shared with the Dean of Students office UDM counseling staff and athletic training staff. I consent to the use or disclosure of protected health information by the UDM Wellness Center to any person or organization for the purposes of carrying out treatment, obtaining payment or conducting certain health care operations. Protected health information used or disclosed by the Wellness Center may include Human Immunodeficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS) related information, psychiatric and other mental health information, and drug and alcohol treatment information, as long as such information is used or disclosed in accordance with Michigan and Federal law, which may require you to provide specific and written authorization. I understand that this consent is effective for as long as the Wellness Center maintains my protected health information, which is 7 years after the last encounter with the Wellness Center, When a health care worker is exposed to my blood or body fluids through a needle stick, cut or splash to the eye or mouth, I agree to have my blood tested for blood-borne diseases to include Hepatitis B and C viruses and HIV. The information I have given is true and accurate to the best of my knowledge. By signing below, I understand and acknowledge the following and give my consent as described above:

_______________________________________   _______________________________   _______________
Student Signature   Parent Signature (If student is under 18)   Date

IMMUNIZATION HISTORY (section to be completed by student)

An accurate immunization history is required of all new students regardless of age. This document must be signed by a health care professional and returned. **Alternatively, you may supply an official immunization record as provided by your health care provider.** All dates must include month/day/year.

Student's Name: (first / middle / last) ___________________________ T#: T0_____________

Date of Birth: (mm/dd/yyyy)______________ Date of Enrollment: (mm/yyyy) ________________

Student's Signature: ________________________________ Date: (mm/dd/yyyy) ___________

TO BE COMPLETED & SIGNED BY A HEALTH CARE PROVIDER (section to be completed by health care provider)

VACCINES	DATES GIVEN (mm/dd/yyyy)
Tdap or Td	☐ Tdap ☐ Td Date 1 ________________
MMR	Date 1 ________________ Date 2 ____________ OR Positive Titer Dates: Measles ___________ Mumps _______________ Rubella ____________
Meningococcal (Menactra)	Living in campus-based housing? ☐ Yes ☐ No Date 1 _______________ Date 2 _______________
Varicella (Chicken Pox)	1: Immunization: Date 1 ______________ Date 2 ______________ OR Positive Titer Dates: ______________ 2. History of Disease: ☐ Yes ☐ No
Hepatitis B	Date 1 ____________ Date 2 ______________ Date 3 ___________ OR Positive Titer Date: __________________
Latex Allergy	☐ Yes ☐ No

Health Care Provider's Signature: __________________________ Phone: ________________________

Health Care Provider's Name (printed) ____________________________ Date (dd/mm/yyyy) __________

Health Care Provider's Address: _______________________ City: _________________

State / Providence: _______ Zip / Postal Code: ________ Country: _____________________________

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required by law to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This notice takes effect on April 14, 2007 and will remain in effect until it is amended and replaced by us. You may request a copy of our Privacy Notice at any time by contacting the UDM Health Center

We will keep your health information confidential, using it only for the following purposes:

Treatment: We may use your health information to provide you with our professional services. We have established "minimum necessary or need to know" standards that limit various staff members' access to your health information according to their primary job function. Everyone on our staff is required to sign a confidentiality statement.

Disclosure: We may disclose and/or share your health information with other healthcare professionals who provide treatment and/or service to you. These professionals will have a similar privacy policy. Health information about you may be disclosed to your family, friends and/or other personas whom you choose to involve in your care, only if you agree that we may do so.

Emergencies: We may, consistent with applicable law and ethical standards of conduct, use or disclose your health information if we believe, in good faith, that such use or disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety.

Health Care Operations: We may use or disclose your protected health information, as necessary, for our own health care operations in order to facilitate the function of our practice and to provide quality care to all patients. Health care operations include the following – quality assessment and improvement, employee review activities, training programs, review and auditing, business management and general administrative activities.

Required by Law: We may use or disclose your health information when we are required by law to do so.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are the possible victim of abuse, neglect or domestic violence or the victim of other crimes. The information will be disclosed only to the extent necessary to prevent serious threat to your health or safety of that of others.

Public Health Responsibilities: We will disclose your health information to report problems with products, reactions to medications, product recalls, disease/infection exposure and disease control, injury and/or disability.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances – lawful intelligence, counterintelligence or other national security activities.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders including but not limited to voicemail messages, postcards or letters.

Your Privacy Rights as our Patient

Access: Upon written request, you have the right to inspect and get copies of your health information. There will be some limited exceptions. If you wish to examine your health information, you can submit a request in writing to The University of Detroit Mercy Health Center 4001 W. McNichols Detroit MI 48221. If you request a copy of the information, we may charge a fee for the cost of copying, mailing and other supplies associated with your request.

Amendments: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be written and must include an explanation of why the information should be amended. Under certain circumstances your request may be denied.

Non-Routine Disclosures: You have a right to receive a list of non-routine disclosures we have made of your health information. When we make a routine disclosure of your information to a professional for treatment purposes we do not keep a record of it, therefore a list is not available. You can request non-routine disclosures going back 10 (ten) years and may not include dates before April 15, 2007.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement unless the information is needed to provide emergency treatment. All requests for additional restrictions must be submitted in writing.

Questions and Complaints

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to The University of Detroit Mercy Health Center Director or Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

How to Contact Us:

Practice Name: **University of Detroit Mercy Health Center**
Phone Number: **313-993-1185**
Fax Number: **313-993-1777**
Address: **104 W. Quad, 4001 W. McNichols, Detroit MI. 48221-3038**

Acknowledgement of Receipt of this Notice:

By signing below, I acknowledge that I have received The University of Detroit Mercy Health Center's Notice of Privacy Practices.

______________________________________ ____________
Signature (Patient or Authorized Representative) Date

______________________________________ ____________
Printed Name (Patient or Authorized Representative) Date of Birth

T#: ____________________________________

EMAIL COMMUNICATIONS

We prefer to not communicate with patients via email due to potential security risks. The best way to communicate with us and maintain privacy of your confidential information is to speak with us in person or on the phone. If you desire to have us communicate with you by email, we prefer to have your consent in advance.

I consent to the Student Health Clinic and Wellness Center communicating with me about my confidential health information via email and acknowledge and accept the risks of communicating my sensitive information by email.

Student's Signature: ______________________________ Date of Birth : (mm/dd/yyyy) ______________

Student T#: ____________________________________

Student's Name: (printed) _________________________ Date: (mm/dd/yyyy) ______________

Parent / Legal Guardian Signature: ___________________ Date: (mm/dd/yyyy) ______________
(If student is under 18)

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