



# McMurry University

## Report of Medical History

### PERSONAL HISTORY

Please answer all questions. Comment on all positive answers in space below.

Have you had or have you now?

	YES	YEAR	NO		YES	YEAR	NO		YES	YEAR	NO		YES	YEAR	NO
German Measles, Rubella				Head injury with unconsciousness				Rheumatic Fever or Heart Murmur				Albumin/Sugar in Urine, Diabetes			
Measles				Dizzy Spells, Fainting				Heart Disease				Kidney Disease			
Mumps				Weakness, Paralysis				High Blood Pressure				Frequent Urination			
Chicken Pox				Tuberculosis				Pain/Pressure in Chest				Inf. Mononucleosis			
Epilepsy, Convulsions				Asthma				Chronic Cough				Inf. Hepatitis			
Eye trouble				Shortness of Breath				Rupture, Hernia				Other Medical Condition Or Surgery List:			
Ear, Nose, Throat trouble				Disease/Injury of Joints, Back				Stomach/Intestine Trouble							
Insomnia				Allergy				Gall Bladder Trouble or Gallstones							
Frequent Anxiety				Penicillin											
Frequent Depression				Sulfonamides				Recurrent Diarrhea				<b>FEMALES ONLY</b>	YES	YEAR	NO
Worry or Nervousness				Serum				Recent Gain or Loss of weight				Irregular Periods			
Recurrent Headaches				Foods								Severe Cramps			
Recurrent Colds				Others: List								Excessive Flow			
Tumor, Cancer, Cyst												Pap Smear Date:			
Venereal Disease												Results:			

Comments:

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### FAMILY HISTORY

	AGE	OCCUPATION	AGE @ DEATH	CAUSE OF DEATH	List details below to YES responses	YES	NO
Father					A. Has your physical activity been restricted during the past five years?		
Mother							
Brothers					B. Have you ever received treatment or counseling for a nervous condition, personality, or character disorder, or emotional problem?		
Sisters					C. Do you take any prescription medications?		
					Comments:		

Student Signature. I certify all questions are answered accurately.

Students may need to be referred off campus for more extensive medical care. Medical insurance is required.

Name of Insurance Company \_\_\_\_\_

Address, City, State, Zip \_\_\_\_\_

Telephone No. \_\_\_\_\_

Subscriber's Name \_\_\_\_\_ SS# \_\_\_\_\_

Employer \_\_\_\_\_ Group ID# \_\_\_\_\_