NORTHERN MICHIGAN UNIVERSITY

ADA B. VIELMETTI HEALTH CENTER
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nmu.edu/HealthCenter

MEDICAL HISTORY FORM

NAME:_____ Date of Birth: _____ DATE: _____

Sex: _____ Is there a nickname you prefer us to call you? If yes, please list: _____

Address:_____

Phone: Home_____ Cell_____ Work_____

NMU IN _____

Citizenship: US Citizen or please list if from another country: _____

Do you have a Primary Care Physician? Yes No PCP Name/Phone/Address_____

HEALTH INSURANCE PLAN: _____

Cardholder Name:_____ **Cardholder Date of Birth**:_____

Policy# _____ Group# _____

Prescription Drug Plan:_____

Emergency Contact:_____ relationship:_____ Phone#_____

Please list all prescriptions and/or over-the-counter medicine taken (include herbal remedies and nutritional supplements). Please list name, how often, how much and how long you have taken. Females: Please include birth control pills, etc. _____

_____

_____

Drug medication allergies, also please note any other environmental, food, or product allergies (i.e. latex) . Please note what type of reaction you may have had. If none, please state NONE

_____

_____

Please list any hospitalizations and any surgeries:

REASON/Operation	Age or date
_____	_____
_____	_____
_____	_____

Check the appropriate space for any illness that you have had in the past, or have presently:

__ Alcoholism
__ Anemia
__ Asthma
__ Bronchitis, chronic
__ Cancer
__ Colitis, spastic/ulcerative
__ Colon Polyps
__ Depression/Anxiety
__ Diabetes Mellitus
__ Ear Infections (frequent)
__ Epilepsy
__ Fibrocystic Breasts
__ Gallbladder problems
__ Gout
__ Gyn/Menstrual Issues
__ Headaches
__ Heart problem(s) other than murmur
__ Hepatitis
__ Herpes, genital
__ High Blood Pressure
__ Hypoglycemia
__ Kidney infection(s)
__ Kidney Stones
__ Male genital problems, i.e. prostate, urethra, tumor
__ Meningitis
__ Mental illness other than depression _____
__ Mononucleosis
__ Obesity (more than 20% over ideal weight)
__ Pneumonia
__ Sexually transmitted disease
__ Stroke
__ Thyroid Disorder
__ Ulcers

List any other chronic medical problems/concerns:

_____

_____

Family Medical History (Check the appropriate space for any illness that has occurred in a blood relative – parent, grandparent, brother, sister and children)

__ Alcoholism __ Anemia __ Bleeding Tendency __Cancer __Colon polyps __ Diabetes Mellitus
__ Heart Problems __ High Blood Pressure __Mental Illness __ Migraines __ Obesity __ Rheumatoid Arthritis
__ Stroke __ Suicide __ Thyroid Disorder __ Tuberculosis __ Ulcers __ Other: please explain

_____

Do you exercise regularly? Y N What do you do?_____ How often?_____
Do you smoke? Chew tobacco? Y N How much?_____ How long?_____
Do you drink alcohol? Y N How much?_____ How often?_____
Do you use street drugs? Y N How much?_____ How long?_____
Have you ever been treated for drug abuse? Y N
Are you satisfied with your weight? Y N Please Explain:_____

MALES/FEMALES: Last Health Exam/Results_____
Last vision exam/results:_____ Last dental exam/results:_____

FEMALES: ** Last gynecological exam (Pap) and results:_____ Ever an abnormal pap? Y N
If previous abnormal pap, Laser? Y N Colposcopy/Biopsy Y N Cryo procedure Y N
Pregnant? Y N Unsure Post Partum? Y N Menopausal? Y N Hysterectomy? Y N
What contraceptive methods are you currently using? Please check all that apply if applicable:
__ Abstinence __ Condoms __ Depo-Provera __ IUD __ Nuvaring __ Partner had vasectomy __ Patch __Pill __ Nothing

CONSENTS

1. **HIPAA & RELEASE OF INFORMATION**: The Health Center is committed to protecting the confidentiality of your medical information. We need this record to provide you with quality care and to comply with certain legal requirements. Authorization is hereby granted to the NMU Health Center to release such information as may be deemed necessary in the treatment of a patient, for completion of an admission for a patient and for payment being collected from you, an insurance company or a third party. The undersigned understands this authorization may be revoked at any time, but not retroactive to the release of information made in good faith, on the condition that the NMU Health Center is informed in writing of such revocation. Full policy posted on website: www.nmu.edu/healthcenter and paper copies are available upon request.
2. **ASSIGNMENT** – I hereby assign to NMU Health Center all medical benefits now due and payable to me under any applicable insurance policies (including governmental reimbursements), and hereby direct any insurance companies or government agencies to pay such benefits directly to said establishment and services furnished by said establishment.
3. **FINANCIAL RESPONSIBILITY** – I understand that I remain financially responsible to Northern Michigan University for all charges incurred. I also understand the charges are due and payable to Northern Michigan University. We will file claims to insurance companies on your behalf, but all copay/deductibles and non-covered charges are the patient's responsibility.

Signature: _____ Date:_____

** Patient Portal sign-up is highly encouraged. Visit Summaries, Lab results and refill requests conveyed securely. Valid email address needed, the link to portal is http://www.healthportalsite.com/nmuhc