**NKU Health, Counseling & Student Wellness-Confidential Medical Registration and History**

Circle one: Student-(major \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) Faculty or Staff-(department\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) Visitor

**Date of birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Last Name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**First Name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Middle Initial**\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**City** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**State**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Zip** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Gender** *(circle one*) Male Female **Preferred Pronoun** (circle one) He She They

**I identify as:** (*circle all that apply*) Straight/Heterosexual Gay Lesbian Trans Bi/Pan Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I am currently:** *(circle one)*Married Divorced Widowed Single Living w/ partner Dating

**Preferred Phone #**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (*circle one*) home cell

**Email Address** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_I prefer to be contacted by (*circle one*) email telephone

**Country of Birth** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Any travel outside of USA in last 6 months?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **What countries?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**EMERGENCY CONTACT:**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Telephone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ALLERGIES:** List all allergies (medications, food, environmental or latex). \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICATIONS:** List *ALL* medications that you are currently taking. Include name of drug, dosage, number of times taken per day. Include all vitamins/supplements and over-the-counter medications. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY MEDICAL HISTORY:** Has anyone in your family (parents, siblings, grandparents) ever been diagnosedwiththe following? (*Check applicable condition and list who had that condition*) Adopted- history unknown None apply

|  |  |  |  |
| --- | --- | --- | --- |
|  | Cancer |  | Heart Condition/High blood pressure  |
|  | Heart attack |  | Diabetes  |
|  | Strokes  |  | Other  |

**PERSONAL MEDICAL HISTORY:**

Have you ever had or currently have any of the following? (*Check applicable condition(s*)) None apply

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Anemia  |  | Mono  |  | Heart Conditions  |  | Chronic Diarrhea  |
|  | Asthma  |  | Anxiety  |  | High Blood Pressure  |  | Constipation  |
|  | Chicken Pox  |  | Depression  |  | Thyroid Problems  |  | Diabetes Type 1 or 2 |
|  | Fainting/blackouts  |  | Bipolar  |  | Sickle Cell  |  | STD’s  |
|  | Migraines  |  | Autism/Asperger’s  |  | Blood Clots  |  | UTI’s  |
|  | Pneumonia  |  | ADD/ADHD |  | Cancer Type |  | Irregular periods |
|  | Strep Throat  |  | Eating Disorders  |  | IBS  |  | HIV/AIDs  |

**SURGERIES/PROCEDURES/HOSPITALIZATIONS:** List ANY operations/procedures or hospitalizations (add dates if known) None apply \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SOCIAL HISTORY: IMMUNIZATIONS:** (add dates if known)

|  |  |
| --- | --- |
| Do you drink alcohol? Yes/No # of drinks per week: | TdaP |
| Do you use tobacco products? Yes/No Type/amount: | Influenza |
| Are you a former smoker? Yes/No Quit date: | COVID: Pfizer Moderna Johnson & Johnson |
| Have you used drugs? Yes/No Type & frequency: |  Date:1st 2nd  |
| Are you sexually active? Yes/No Birth control type: |  |

**By signing below, I agree that all the above information is correct.**

**SIGNATURE**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date Form Completed:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(*Office use only*)History reviewed (date & initials)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_