Student Health Services
1405 N. Fourth Ave., PMB 4088
Durant, OK 74701-0609
(580) 745-2867 FAX (580) 745-7567

Date record received in Health Services: _____

PLEASE USE AN INK PEN ONLY

FULL NAME (LAST, FIRST, MIDDLE)			STUDENT ID #	S.S #
DATE OF BIRTH	AGE	SEX ☐ MALE ☐ FEMALE ☐ TRANSGENDER ☐ MTF ☐FTM	EMAIL ADDRESS	
PERMANENT STREET ADDRESS			CITY / STATE / ZIP	
CURRENT STREET ADDRESS			CITY / STATE / ZIP	
CURRENT PHONE	CELL PHONE	MAJOR	CLASSIFICATION: ☐ FRESHMAN ☐ SOPHOMORE ☐ JUNIOR ☐ SENIOR ☐ GRADUATE STUDENT ☐OTHER, EXPLAIN:	
ARE YOU EMPLOYED? ☐ YES ☐ NO	IF YES, WHAT IS YOUR OCCUPATION?		IF APPLICABLE, WHAT IS YOUR SPOUSE'S NAME?	
NAME OF FAMILY PHYSICIAN			PHYSICIAN CONTACT #	

INSURANCE INFORMATION:
SOME FORM OF HEALTH INSURANCE IS STRONGLY ADVISED FOR ALL STUDENTS. PLEASE GIVE CARD TO STAFF FOR COPYING.

SOUTHEASTERN HAS A STUDENT INSURANCE PLAN AVAILABLE, ASK STAFF IF REQUESTING MORE INFORMATION.

PLEASE ATTACH COPY OF IMMUNIZATIONS IF AVAILABLE.

EMERGENCY CONTACT INFORMATION				
EMERGENCY CONTACT NAME	RELATIONSHIP	HOME PHONE	WORK PHONE	
HOME ADDRESS		CITY	STATE	ZIP
ALTERNATE EMERGENCY CONTACT (NEAREST SOSU)	RELATIONSHIP	HOME PHONE	WORKPHONE	
HOME ADDRESS		CITY	STATE	ZIP

MEDICATIONS

ARE YOU CURRENTLY TAKING ANY MEDICATIONS? ☐ YES ☐ NO

IF YES, PLEASE LIST CURRENT MEDICATIONS (INCLUDING OVER THE COUNTER):
_____
_____
_____

DO YOU HAVE ANY MEDICATION ALLERGIES OR OTHER SENSITIVITIES? ☐ YES ☐ NO

IF YES, PROVIDE MEDICATION AND REACTION:
_____
_____
_____

ARE YOU CURRENTLY TAKING VITAMINS, HERBAL PREPARATIONS, OR HOMEOPATHIC REMEDIES? ☐ YES ☐ NO

IF YES, PLEASE LIST:
_____

FAMILY HISTORY

FATHER ☐ LIVING ☐ DECEASED
OCCUPATION _____
AGE AT DEATH _____
CAUSE OF DEATH _____

MOTHER ☐ LIVING ☐ DECEASED
OCCUPATION _____
AGE AT DEATH _____
CAUSE OF DEATH _____

SIBLINGS
NUMBER LIVING _____
NUMBER DECEASED _____
DO YOU HAVE A TWIN? ☐ YES ☐ NO

MEDICAL HISTORY

PERSONAL HISTORY		SPECIFY		FAMILY HISTORY		RELATIONSHIP/SPECIFY
☐ YES	☐ NO	_____	ALLERGIES / ALLERGY INJECTIONS			
☐ YES	☐ NO	_____	BONE OR JOINT PAIN/DISABILITY/INJURY (EX: GOUT, OSTEOPOROSIS, ARTHRITIS)	☐ YES	☐ NO	_____
☐ YES	☐ NO	_____	CANCER	☐ YES	☐ NO	_____
☐ YES	☐ NO	_____	DIABETES	☐ YES	☐ NO	_____
☐ YES	☐ NO	_____	GASTROINTESTINAL PROBLEMS (EX: COLITIS, ULCERS)	☐ YES	☐ NO	_____
☐ YES	☐ NO	_____	HEADACHES (DIFFERENTIATE TYPE IF KNOWN)			
☐ YES	☐ NO	_____	HEARING IMPAIRMENT			
☐ YES	☐ NO	_____	HEART DISEASE / DEFECT / INCIDENT	☐ YES	☐ NO	_____
☐ YES	☐ NO	_____	HIGH / LOW BLOOD PRESSURE / CHOLESTEROL	☐ YES	☐ NO	_____
☐ YES	☐ NO	_____	LIVER DISEASE / HEPATITIS (TYPE)	☐ YES	☐ NO	_____
☐ YES	☐ NO	_____	MENTAL ILLNESS (EX : DEPRESSION, ANXIETY, EATING DISORDER)	☐ YES	☐ NO	_____
☐ YES	☐ NO	_____	NEUROLOGICAL DISORDER	☐ YES	☐ NO	_____
☐ YES	☐ NO	_____	RESPIRATORY DISEASE / PROBLEM (EX: ASTHMA, CHRONIC BRONCHITIS)	☐ YES	☐ NO	_____
☐ YES	☐ NO	_____	SKIN PROBLEMS (EX:ECZEMA, PSORIASIS, ACNE, HIVES)	☐ YES	☐ NO	_____
☐ YES	☐ NO	_____	THYROID DISEASE	☐ YES	☐ NO	_____
☐ YES	☐ NO	_____	VISUAL IMPAIRMENTS / EYE DISEASE ☐ GLASSES ☐ CONTACTS			
☐ YES	☐ NO	_____	OTHER	☐ YES	☐ NO	_____

HOSPITALIZATIONS/SURGICAL HISTORY

YEAR	ILLNESS OR OPERATION	YEAR	ILLNESS OR OPERATION

FEMALES ONLY

AGE OF FIRST MENSTRUAL CYCLE	AVERAGE NUMBER OF DAYS FOR MENSTRUAL FLOW	LENGTH OF CYCLE	DATE OF LAST PERIOD (1ST DAY OF CYCLE
MENSTRUAL FLOW ☐ REGULAR ☐ IRREGULAR ☐ PAIN/CRAMPS	BLEEDING OR SPOTTING BETWEEN PERIODS? ☐YES ☐ NO	DO YOU HAVE PAIN OR BLEEDING DURING OR AFTER SEX? ☐ YES ☐ NO	
DATE OF LAST PAP SMEAR* _____ ANY CHRONIC URINARY OR BLADDER INFECTIONS? ☐ YES ☐ NO	HAVE YOU EVER HAD AN ABNORMAL PAP SMEAR? ☐ YES ☐ NO IF YES, PLEASE PROVIDE DATES _____		
HAVE YOU EVER BEEN PREGNANT? ☐ YES ☐ NO IF YES, NUMBER OF: PREGNANCIES _____ ABORTIONS _____ MISCARRIAGES_____ LIVE BIRTHS_____	LAST BREAST EXAM*_____	DATE OF LAST MAMMOGRAM* _____	
	***MONTHLY SELF-BREAST EXAMS ARE RECOMMENDED FOR ALL WOMEN. ANNUAL GYNECOLOGY EXAMS SHOULD BEGIN AT AGE 21 OR WHEN A FEMALE FIRST BECOMES SEXUALLY ACTIVE. WOMEN 40 AND OLDER SHOULD HAVE ANNUAL MAMMOGRAMS, EARLIER IN SOME CIRCUMSTANCES.**		

MALES ONLY

LAST TESTICULAR EXAM* _____	HAVE YOU HAD A TESTICULAR MASS OR SURGERY ☐ YES ☐ NO IF YES, PLEASE EXPLAIN: _____	
LAST PROSTATE EXAM _____	HAVE YOU HAD PROSTATE INFECTION OR SURGERY? ☐ YES ☐ NO	HAVE YOU HAD UNDESCENDED TESTICLES? ☐ YES ☐ NO
HAVE YOU FATHERED A CHILD? ☐ YES ☐ NO	*** TESTICULAR SELF EXAMS ARE RECOMMENDED MONTHLY FOR ALL MEN**	

PERSONAL HISTORY / HEALTH RISKS

HEIGHT	WEIGHT	SEXUAL IDENTITY: ☐ HETEROSEXUAL ☐ LESBIAN / GAY / HOMOSEXUAL ☐ BISEXUAL ☐ QUESTIONING		
RELATIONSHIP STATUS: ☐ SINGLE ☐ LEGALLY MARRIED ☐ DOMESTIC PARTNER RELATIONSHIP ☐ DIVORCED / SEPARATED ☐ WIDOWED ☐ OTHER PLEASE SPECIFY:				
ETHNICITY: ☐ ASIAN / PACIFIC ISLANDS ☐ AFRICAN AMERICAN ☐ CAUCASIAN ☐ NATIVE AMERICAN ☐ HISPANIC ☐ OTHER / MULTICULTURAL		ARE YOU BEING TREATED FOR A MEDICAL PROBLEM ON AN ONGOING BASIS? ☐ YES ☐ NO IF YES, PLEASE EXPLAIN:		
DO YOU HAVE A DISABILITY? ☐ YES ☐ NO IF YES, PLEASE LIST:	HAVE YOU EVER RECEIVED SERVICES FOR A DISABILITY? ☐ YES ☐ NO	DO YOU HAVE A NEED FOR HANDICAPPED ACCESS? ☐ YES ☐ NO	WOULD YOU LIKE INFO ON SOSU DISABILITY SERVICES? ☐ YES ☐ NO	
DO YOU SMOKE? ☐ YES ☐ NO HOW MUCH? ☐≤ PACK PER DAY ☐≥ PACK PER DAY☐≤ PACK PER WEEK ☐≥ PACK PER WEEK	DO YOU USE SMOKELESS TOBACCO? ☐ YES ☐ NO	DO YOU WANT TO QUIT SMOKING/TOBACCO? ☐YES ☐ NO	DO YOU LIVE / WORK IN A SMOKING ENVIRONMENT? ☐ YES ☐ NO	
I DRINK ALCOHOL: ☐ NEVER ☐DAILY ☐ WEEKLY ☐MONTHLY ☐OCCASIONALLY WHEN I DO DRINK, I TYPICALLY HAVE: ☐ ≤12 OZ. BEER OR 5 OZ. WINE OR 1.5 OZ.OF 80 PROOF LIQUOR ☐ >12 OZ. BEER OR 5 OZ. WINE OR 1.5 OZ.OF 80 PROOF LIQUOR			DO YOU DRIVE AFTER DRINKING ALCOHOL? ☐ YES ☐ NO	
HOW MANY CAFFEINATED BEVERAGES DO YOU DRINK PER DAY? ☐ NONE ☐≤ 12 OZ. ☐≥ 12 OZ.	HAVE YOU EVER USED RECREATIONAL DRUGS? ☐ YES ☐ NO IF YES, PLEASE LIST TYPE:		ARE YOU OR HAVE YOU BEEN IN A RELATIONSHIP IN WHICH YOU HAVE BEEN EMOTIONALLY OR PHYSICALLY ABUSED OR THREATENED? ☐ YES ☐ NO	
HAVE YOU EVER HAD SEXUAL INTERCOURSE? ☐ YES ☐ NO	IF YES, AGE OF FIRST SEXUAL ENCOUNTER	IF YES, HOW MANY PARTNERS HAVE YOU HAD?	HAVE YOUR PARTNERS BEEN: ☐ MALE ☐ FEMALE ☐ BOTH	
IS BIRTH CONTROL NECESSARY? ☐ YES ☐ NO	LIST ALL METHODS IN USE ☐ CONDOM ☐ PILL ☐ SHOT ☐ PATCH ☐ RING ☐ IUD OTHER:		DO ANY CHILDREN LIVE IN YOUR CURRENT HOUSEHOLD? ☐ YES ☐ NO	
HAVE YOU EVER BEEN EXPOSED TO A SEXUALLY TRANSMITTED DISEASE? ☐ YES ☐ NO	DATE OF LAST STD SCREENING		HAVE YOU EVER BEEN FORCED INTO UNWANTED SEXUAL ACTIVITY? ☐ YES ☐ NO	
OVER THE PAST 2 WEEKS, HOW OFTEN HAVE YOU BEEN BOTHERED BY ANY OF THE FOLLOWING PROBLEMS? 1. LITTLE INTEREST OR PLEASURE IN DOING THINGS ☐NOT AT ALL ☐SEVERAL DAYS ☐MORE THAN HALF THE DAYS ☐NEARLY EVERY DAY 2. FEELING DOWN, DEPRESSED, OR HOPELESS ☐NOT AT ALL ☐SEVERAL DAYS ☐MORE THAN HALF THE DAYS ☐NEARLY EVERY DAY				

SELF CARE ROUTINE

DO YOU EXERCISE ☐ YES ☐ NO ☐ CARDIO ☐ STRENGTH ☐ FLEXABILITY HOW OFTEN? ☐DAILY ☐WEEKLY ☐MONTHLY ☐OCCASIONALLY	DO YOU EAT A BALANCED DIET IN A 24 HOUR PERIOD? ☐ YES ☐ NO IF NO WHAT IS LACKING IN YOUR DIET? ☐ FRUIT ☐ MEAT ☐ BREAD/CEREAL ☐ VEGETABLES ☐ DAIRY PRODUCTS
DO YOU WEAR A SEATBELT? ☐ YES ☐ NO	WHEN YOU LOOK IN THE MIRROR HOW DO YOU SEE YOURSELF? ☐ THIN ☐ JUST RIGHT ☐ OVER WEIGHT ☐ OBESE

I HEREBY CERTIFY THE INCLUDED PERSONAL/HEALTH INFORMATION IS COMPLETE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

AUTHORIZATION FOR TREATMENT: BY VIRTUE OF MY SIGNATURE I AUTHORIZE SOUTHEASTERN OKLAHOMA STATE UNIVERSITY AND ANY OF ITS EMPLOYEES OR OTHER AUTHORIZED PERSONNEL OR AGENTS TO PROVIDE GENERAL HEALTHCARE SERVICES TO ME.

_____ _____

STUDENT SIGNATURE DATE