**Wellness Center - Health Services**
**220 Pawtucket St., Suite 300**
**Lowell, MA 01854-5144**
**Tel: (978) 934-6800**

# Health History
**Part 1**

Name: _____ Male Female Transgender Date of Birth: _____
Last First Month/Day/Year

Student ID# _____ Home Phone: _____ Cell Phone _____

Permanent Address _____
Street Address (Including Apt. #) City/State Country

Birth place (Country) _____ Email _____

Date Entering UMass Lowell _____ Entering as: Undergraduate Graduate Residential Commuter

## Primary Emergency Contact Information

Name _____ Relationship _____

Address _____

Home Phone _____ Cell Phone _____ Business Phone _____

## Alternate Emergency Contact

Name _____ Relationship _____

Address _____

Home Phone _____ Cell Phone _____ Business Phone _____

## Primary Health Care Provider

Name _____

Address _____ Phone _____

## Health Insurance Coverage

Name of Company _____

Subscriber Name _____ Group # _____ ID# _____

## Consent for Medical Treatment

(Consent is required ONLY if student will be under 18 years old at the start of the semester.)

**I hereby give permission for medical treatment for my dependent if an accident or illness should occur while my dependent is a student at the University of Massachusetts Lowell. This includes assessment and treatment at the Wellness Center, as well as, referral to a local hospital or hospitalization should it be necessary and I am unable to be reached. This may also include medical care related to immunizations, examinations, treatments, and obtaining lab specimens.**

**I grant this permission be valid until my dependent is 18 years old while a student at the University of Massachusetts Lowell.**

_____

**Name Parent/Guardian (print)** **Signature** **Date**

**Upload the Health History form directly into the Student Health Portal at https://patient-uml.medicatconnect.com/. If unable to access the portal, mail or bring to Health Services, UMass Lowell, 220 Pawtucket Street, Suite 300, Lowell, MA 01854-5144.**

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# Health History
## Part 2

**Name:** _____
Last First Student ID# Date of Birth

| Family History | | | | |
|---|---|---|---|---|
| | **Age** | **State of Health** | **Age of Death** | **Cause of Death** |
| Father | | | | |
| Mother | | | | |
| Brothers | | | | |
| | | | | |
| Sisters | | | | |
| | | | | |
| Spouse | | | | |
| Children | | | | |

| **Have any of your immediate relatives had any of the following:** | **Yes** | **Relationship** |
|---|---|---|
| Alcohol/Substance Abuse | | |
| Allergy / Asthma | | |
| Cancer | | |
| Diabetes | | |
| Heart Disease | | |
| High Blood Pressure | | |
| Kidney Disease | | |
| Mental Illness | | |
| Neuromuscular Disease | | |
| Other | | |

**Personal History**
(Do you have now or have you ever had: Check all that apply and provide details.)

| | | | |
|---|---|---|---|
| **ADD/ADHD** | **Drug/Alcohol Abuse** | **Irritable Bowel Syndrome** | **Sexually Transmitted Infections** |
| **Anemia (type)** | **Eating Disorders** | **Kidney Disease/Stones** | **Sickle Cell Disease** |
| **Anxiety** | **Emotional/Mental Health Illness** | **Malaria** | **Thyroid Disease** |
| **Arthritis** | **Fractures/Dislocations/Tears** | **Meningitis** | **Tuberculosis Disease/Positive TB test** |
| **Asthma** | **Heart Murmur/Arrhythmia** | **Migraines/Chronic Headaches** | **Ulcers** |
| **Cancer/Malignancy** | **Hepatitis (type)** | **Mononucleosis** | **Urinary Tract Infection (frequent/recurrent)** |
| **Concussion/Severe Head Injury** | **High Blood Pressure** | **Phlebitis/Deep Vein Clot** | **Visual Impairment/Blind** |
| **Crohn's/Ulcerative Colitis** | **High Cholesterol** | **Pneumothorax** | **Other** |
| **Depression** | **Impaired Mobility/Paralysis** | **Rheumatic Fever** | **I do not have any personal health history to disclose.** |
| **Diabetes (type)** | **Insomnia** | **Seizure Disorder** | |

**Hospitalizations:** (Please list all medical/psychiatric hospitalizations, surgeries, dates, diagnoses.)

**Medications:** (Please list all prescription and over-the-counter medications including supplements, vitamins, etc.)

**Allergies:** (Please specify and include type of reaction.)
None Known Medications Food Environment Insects

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