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 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 your completed Health History form directly into the Student Health Portal at https://patient-uml.medicatconnect.com/.
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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

Your Personal History will be reviewed at your first visit to Health Services.

(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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