

Medical History

University of Iowa Student Health Service

The University of Iowa Student Health Service requests this confidential information for the purpose of providing patient care. Persons outside the Student Health Service are not routinely provided this information without the patient's knowledge and written consent. Responses to all items are required in order to facilitate appropriate patient care.

-Label-

A. Personal Data

Gender: Male Female Other

| | | | | | |
|------------------------------------|------------|--------|-------------|---------------|--|
| Last name | first name | middle | Student ID# | | |
| Home address (number, street) | city | state | zip | date of birth | |
| Emergency contact person (address) | | | | telephone | |

B. Personal Medical History

Do you have or have you had any of the following? (**Respond to every item. For items marked "Y" make comments in part H**)

| | Y | N | | Y | N | | Y | N |
|---------------------------------------|---|---|-----------------------------|---|---|------------------------------------|---|---|
| Eye disorders (not corrective lenses) | | | Disease or injury of joints | | | Jaundice or hepatitis | | |
| Ear, nose, throat problems | | | High blood pressure | | | Stomach or intestinal problems | | |
| Genetic disorder | | | Tuberculosis | | | Tumor or cancer | | |
| Diabetes | | | Convulsive disorder | | | Weakness or paralysis | | |
| Head injury | | | Rheumatic fever | | | High cholesterol (specify results) | | |
| Hay fever | | | Heart problems | | | Sexually transmitted infection | | |
| Asthma | | | Back problems | | | Menstrual irregularity | | |
| Hemophilia | | | Other : | | | | | |

Have you ever been hospitalized or had surgery? If so, please specify _____

Have you ever had treatment for a mental health condition? _____

List any medications you currently take: (include over the counter meds, contraceptives, herbal drugs, or supplements) _____

List any allergies to: Medications (list type of reaction you had) _____

Food or environmental allergens: _____

C. Family History

1. Background about your immediate family:

| | Age | Occupation | Any health problems? |
|----------|-----|------------|----------------------|
| Father | | | |
| Mother | | | |
| Brothers | | | |
| | | | |
| Sisters | | | |
| | | | |

2. Have any of your relatives had the following (state relationship to you):

| | Y | N | Relationship | | Y | N | Relationship |
|---------------------|---|---|--------------|---------------|---|---|--------------|
| High blood pressure | | | | Cancer | | | |
| High cholesterol | | | | Stroke | | | |
| Tuberculosis | | | | Psychiatric | | | |
| Diabetes | | | | Arthritis | | | |
| Heart disease | | | | Epilepsy | | | |
| Kidney disease | | | | Alcohol/drugs | | | |
| Hereditary disease | | | | | | | |

D. Social History

1. Do you engage in exercise? yes no (If yes, how often and what form?) _____
2. What is/will be your living arrangement? (e.g. Residence Hall or apartment) _____
3. Do you have any weight or eating concerns? _____
4. Do you know how to protect yourself from sexually transmitted infections? yes no
5. Do you use tobacco? yes no (If yes, indicate how much and for how long.) _____
6. Do you drink alcohol? yes no (If yes, indicate how much and how often.) _____
7. Do you require assistance completing your normal daily activities? yes no (If yes, please describe) _____
8. Do you have any difficulty understanding English? yes no What is your primary language? _____
9. How do you prefer to learn? (check as many as apply) Read___ Write___ Listen___ Observe___ Perform___ Other___
10. Please describe any circumstances that affect your ability to understand and learn about health issues _____
11. If you will require an interpreter or other communication assistance, please inform the scheduler when scheduling your appointment.
12. If you have any Advance Directives, such as a living will, please send a copy with this form.

E. Verification:

Student signature _____

Date _____

Return this form to: Student Health Service, The University of Iowa, 4189 Westlawn, Iowa City, IA 52242-1100

University of Iowa Student Health Service

Authorization for Release of Information and Payment Request

| |
|-------------------|
| Name _____ |
| Birth Date _____ |
| Student ID# _____ |

I. Insurance, payment information and assignment of benefits

- I request The University of Iowa Student Health Service (SHS) to submit claims on my behalf to my insurance company, Medicare, or other third party payor for my care and authorize disclosure of health information to the extent necessary to obtain payment.
- In consideration of the health care services provided to the Patient, I assign and authorize my insurance company, Medicare, or other third party payor to make payments directly to SHS including charges for physician services.
- I have been informed that:
 - I must pay all charges, co-payments, deductibles, and coinsurance not covered by my insurance company, Medicare, or third party payor, and these will be charged to my UBill.
 - I must pay all charges incurred if I lack insurance coverage and will also contact SHS to work with them to identify financial options available for me.
 - The policy holder of my health insurance may receive information pertaining to my visits.
 - I may revoke this consent to release medical information at any time by sending a written notice to Student Health Service, 4189 Westlawn, University of Iowa, Iowa City, Iowa 52242. Except as provided below * this release is valid until revoked.
- I authorize SHS to share my third party payor information with The University of Iowa Hospitals and Clinics.
- I agree to pay for non-covered services or services not covered as a result of my failure to obtain pre-authorization for treatment as required by any such payor, or agreed upon services deemed as medically unnecessary by the payor.
- SHS will use good faith efforts to protect patient's right to confidentiality in appropriately providing health information to payors.

II. Specific Authorization for Release of Information

I specifically authorize SHS to submit medical information regarding diagnoses, treatment, consultations, prescriptions, and medical history to my insurance company, Medicare, or other third party payor or its authorized agents or representatives for the purpose of determining benefits and facilitating payment. This authorization is valid for one (1) year*. Disclosures may only be made pursuant to the written authorization of an individual or an individual's legal representative. The unauthorized disclosure of this information is unlawful and civil damages and criminal penalties may be applicable to the unauthorized disclosure of said information pursuant to the Iowa code. I may revoke this specific consent to release information at any time by sending a written notice to Student Health Service, 4189 Westlawn, University of Iowa, Iowa City, Iowa 52242. I understand that the information to be released may include information in the following categories unless I specifically deny the release (**initial** any category **not** to be released).

_____ Substance Abuse

_____ Acquired Immune Deficiency Syndrome (AIDS)
including Human Immuno-deficiency Virus (HIV)

_____ * Mental Health (valid for two years)

Patient Signature/Responsible Person
(Patient must be 18 or over to sign)

Date Signed

Relationship/Legal Title (if not patient)

Witness

Date Signed

Witness

Date Signed

Please complete the back side of this form

**University of Iowa
Student Health Service
INSURANCE INFORMATION**

| |
|-------------------|
| Name _____ |
| Birth Date _____ |
| Student ID# _____ |

PLEASE INCLUDE A COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD

I. Primary Policyholder Information:

Name of Policyholder: _____
Address of Policyholder: _____
(Street) (City) (State) (Zip)
Phone of Policyholder: (____) _____ -- _____
Birth Date of Policyholder: ____/____/____
Relationship to Patient: Self Spouse Partner Father Mother Other _____

Primary Insurance Information:

Insurance Company: _____
Address of Insurance Co: _____
Phone Number(s): (____) _____ -- _____; (____) _____ -- _____
Policy Number: _____
Group Number: _____
Employer of Policyholder: _____

****Do you have other health insurance? ___ Yes ___ No If yes, please complete the following information:**

II. Secondary Policyholder Information:

Name of Policyholder: _____
Address of Policyholder: _____
(Street) (City) (State) (Zip)
Phone of Policyholder: (____) _____ -- _____
Birth Date of Policyholder: ____/____/____
Relationship to Patient: Self Spouse Partner Father Mother Other _____

Secondary Insurance Information:

Insurance Company: _____
Address of Insurance Co: _____
Phone Number(s): (____) _____ -- _____; (____) _____ -- _____
Policy Number: _____
Group Number: _____
Employer of Policyholder: _____

WE RECOMMEND THAT YOU HAVE YOUR INSURANCE CARD WITH YOU AT SCHOOL

Return this form to: Student Health Service University of Iowa 4189 Westlawn Iowa City, IA 52242-1100