LAFENE HEALTH CENTER
Kansas State University, 1105 Sunset Ave, Manhattan KS 66502

Telephone: (785)532-6544
Fax: (785)532-3425

MEDICAL HISTORY

FILL OUT THIS FORM COMPLETELY. PRINT LEGIBLY. Attach a legible copy of your immunization record. Completion of this is required **before** receiving non-urgent care at Lafene Health Center.

Today's Date:		
Last Name:	First Name:	Middle Initial:
Wildcat ID #:	Date of Birth:	

Email Address:	
Mailing Address:	
Primary Phone Number:	Secondary Phone Number:

CITIZENSHIP:
☐ US Citizen
☐ Other Citizen
☐ Foreign Born
List Country:
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STUDENT STATUS:
☐ Undergraduate
☐ Graduate Student
☐ Other Student
☐ KSU Employee
☐ Spouse
☐ Visitor

ETHNICITY:
☐ American Indian/ Alaska Native
☐ Asian
☐ Black
☐ Hispanic/Latino
☐ Native Hawaiian or Pacific Islander
☐ White
☐ Other_________

MARITAL STATUS:
☐ Single
☐ Married
☐ Divorced
☐ Widowed

GENDER:
☐ Male
☐ Female
☐ Transgender

EMERGENCY CONTACT:

Name:		Relationship:	Phone Number:	
Street Address:		City:	State:	Zip Code:

CURRENT INSURANCE INFORMATION:

Please submit by mail or in person to Lafene Health Center, 1105 Sunset Ave, Manhattan KS 66502, one copy of the front and back of each medical and pharmaceutical card for this patient. Please include the following additional information: **Patient's name, Wildcat ID number, Policy Holder's name, Policy Holder's date of birth, Patient's relationship to Policy Holder, Policy Holder's address (including street, city, state and zip) & phone number.**
If you mail or fax your insurance information, please confirm with the Insurance Department that we did receive your insurance information. It is the patient's responsibility to make sure we receive all necessary insurance information for filing claims. **All insurance claims will be filed with your insurance company unless you request otherwise.** If you have any questions, call our Insurance Department at (785)532-6749. Thank you.

☐ Mark this box if you attended a KANSAS high school.

ALLERGIES or REACTIONS TO MEDICINES, FOODS: (example: penicillin, peanuts, bee stings, latex)

Medications:	Food:
Insect stings:	Other:

CURRENT MEDICATIONS (INCLUDE DOSE & FREQUENCY): Include prescriptions, birth control, over the counter & herbal.

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PLEASE COMPLETE THE OTHER SIDE.

Name:________________________________ WID:____________________________

PRIMARY CARE PHYSICIAN INFORMATION:

Name:		Phone Number:	
Street Address:	City:	State:	Zip Code:

LIST CHRONIC MEDICAL CONDITIONS, HOSPITALIZATIONS AND/OR SURGERIES WITH DATES:

Please list:

☐ **Mark this box if you were adopted.**
☐ **Lived / traveled in another country more than 3 months (list country)____________________**

HEALTH & FAMILY HISTORY: Mark all that apply.

	Relationship								
	SELF	Mother	Father	Sister	Brother	Grandmother (maternal)	Grandmother (paternal)	Grandfather (maternal)	Grandfather (paternal)
AutoImmune Disorder									
Lupus									
Rheumatoid Arthritis									
Other:									
Behavioral Health									
ADD/ADHD									
Alcoholism/Addiction									
Anxiety									
Bipolar Disorder									
Depression									
Eating Disorder									
Suicide attempt/Suicide									
Other:									
Cancer: (type)_____________									
Cardiovascular									
Blood Clot (arms/legs/lungs)									
Heart Disease									
High cholesterol									
High blood pressure									
Sudden death before age 50									
Other:									
Endocrine									
Diabetes									
Thyroid disease									
Other:									
Gastrointestinal									
Crohn's Disease/ Ulcerative Colitis									
Heartburn/ulcer									
Liver Disease/Hepatitis									
Other:									
Neurological									
Seizures									
Severe Headaches/ Migraines									
Stroke									
Other:									
Respiratory									
Asthma									
History of Pneumonia									
Other:									
Other:									