OLLU

OUR LADY OF THE LAKE UNIVERSITY

PLEASE PRINT NEATLY

Health Services Ext. 2341

411 S.W. 24TH STREET • SAN ANTONIO, TEXAS 78207 • 210-434-6711

Patient's Name_____ Sex: ☐ Female ☐ Male

Next of kin or person to notify in case of emergency:

Name_____ Relation_____ Phone_____

Address_____
Street City State Zip

Health Insurance

Name of Insured_____ Insurance Company_____

Policy Number_____ Phone_____

Medical History

Have you ever had: (Please check You or Identify Other)

*(**M**-Mother **F**-Father **B**-Brother **S**-Sister **MGM**-Mother's Mother **MGF**-Mother's Father **PGM**-Father's Mother **PGF**-Father's Father)*

	You	Other		You	Other		You	Other
Head Injury			High Blood Pressure			Thyroid Disorder		
Migraines			Heart Attack			Diabetes		
Convulsions/Seizures			Heart Disease			Hepatitis		
Stroke			High Cholesterol			Ulcers		
Meningitis			Heart Murmur			Prostate Problems		
Anxiety			Artificial Heart Valves			Bladder Infection		
Depression			Rheum. Fever			STD: _____		
Mental Illness			Blood Transfusion			Substance Abuse		
Allergies			HIV / AIDS			Low Back Pain		
Asthma			Cancer			Herniated Discs		
Bronchitis			Tuberculosis			Arthritis		
Pneumonia			Anemia			Gout		

Other medical history or comments on any of the above: _____

Have you had any major surgery? ☐ Yes ☐ No Describe _____

Are you presently being treated for a medical condition? ☐ Yes ☐ No Current Medications: _____

_____

▲ **To insure appropriate treatment, please identify the specific name of any medication you are currently taking.** ▲

Social History

Are you: ☐ Married ☐ Single ☐ Divorced ☐ Widowed Occupation: _____

Do you smoke? ☐ Yes ☐ No If yes, please indicate the number of cigarettes smoked a day: _____.

Do you drink alcohol? ☐ Yes ☐ No If yes, please indicate the number of drinks consumed per week: _____.

Allergy History

Are you allergic to: Medications? ☐ Yes ☐ No Describe _____ Reaction _____

Insects? ☐ Yes ☐ No Describe _____ Reaction _____

Foods? ☐ Yes ☐ No Describe _____ Reaction _____

Pollens, molds, or other inhalants? ☐ Yes ☐ No Describe _____ Reaction _____

Note: All of the above information is strictly confidential and will be managed according to HIPPA guidelines. (See attached)

I authorize Sarah Gormican, FNP and the Office of Health Services at Our Lady of the Lake University to administer medical services and therapeutic procedures as deemed necessary for the treatment of myself.

Patient's Signature_____ Date _____/_____/_____

For Health Services Use Only: Date Received _____/_____/_____ ☐ Complete ☐ Incomplete Needs:_____

Date Reviewed _____/_____/_____ ☐ Complete ☐ Incomplete Needs:_____

_____ Date Reviewed _____/_____/_____ ☐ Complete ☐ Incomplete Needs:_____