

HEALTH HISTORY FORM

OFFICE OF STUDENT HEALTH

Name	Age	Phone		_Date	
Type of Student: Medical / Gradu	ate / Nursing / S	pouse / Child			
Martial Status: Single / Married / I Age and sex of children:	Divorced / Separa	ated / Widowed			
MEDICAL HISTORY			Yes	No	
Any operations, serious injuries, Hospi Specify:	talizations?				
Allergic reactions to medicine? (Specify medicine, type of reaction)				_	
Do you regularly take or use any of the Prescription medications?	_				
Non-prescription medications	s ?			_	
Have you ever had the following:					
Chicken Pox? (If yes, what y	ear?)				
Asthma?					
Hay fever, hives, other allerg Previously mentioned?	ies not				
High blood pressure?					
Heart murmur, other disorder	rs of the heart?				
Diabetes, thyroid, or other en	docrine disorders?				
"Disc" problems, other disord bones, joints?	ders of muscles,				
Frequent or severe headaches Concussion, convulsion?	s, head injury or				
Other serious symptoms or illness we s Please specify: Women:	hould know about	?			
Menstrual cycle disorders?					
Any history of vaginal or urin	nary infections?				
When was you last PAP test?					

Any history of genital or urinary infections?					
REMARKS: PERSONAL HEALTH BEHAVIOR		Yes	No		
Do you have concerns about your weight?					
Have you lost or gained 10 or more pounds in the past 6 months?			_		
Do you feel you are eating well?					
Do you exercise regularly? How often?times a week formin	nutes.		_		
Do you practice safe sex? Please circle: abstinence or us	e of condoms		_		
Do you smoke cigarettes? If yes, how long?mon	nthsyears				
How many cigarettes do you smoke each day?					
Do you drink alcohol?					
How much on average?					
Have you ever felt you ought to cut down on your drinkin -ever been annoyed by people criticizing your d -ever felt bad or guilty about your drinking? -ever had a morning "Eye Opener" to steady yo	lrinking?				
Have you ever used recreational drugs?					
Do you feel you are under undue stress?					
Is there someone with whom you can always discuss your personal problems? Who would that be?					
Are you feeling sad/depressed?					
Have you ever been treated for depression?					
Do you have any problems sleeping?			_		
Do you have any other health care concerns? Please elaborate:			_		
Family History: Please document who in the family had to (Key: M-Mother; F-Father; MGF-Maternal Grandfather; B-Brother; S-Sister)		ndmother; PGM-Pate	ernal grandmother PGF-Paternal		
AlcoholismHeart	t disease/heart attack				
CancerHigh	High blood pressure				
DiabetesHigh	High cholesterol/triglycerides				
Mental IllnessTB					
GlaucomaOther	r (specify)				
DO NOT WRITE BELOW THIS LINE					

_MD, CRNP, PA