PENNSTATE
Milton S. Hershey Medical Center
College of Medicine

HEALTH HISTORY FORM

OFFICE OF STUDENT HEALTH

Name _____**Age**_____**Phone** _____**Date**_____

Type of Student: Medical / Graduate / Nursing / Spouse / Child

Martial Status: Single / Married / Divorced / Separated / Widowed
Age and sex of children:

MEDICAL HISTORY	**Yes**	**No**
Any operations, serious injuries, Hospitalizations? Specify:	___	___
Allergic reactions to medicine? (Specify medicine, type of reaction) _____ _____ _____	___	___
Do you regularly take or use any of the following: Prescription medications? _____ _____	___	___
Non-prescription medications? _____ _____ _____	___	___

Have you ever had the following:

Chicken Pox? (If yes, what year? _____)	___	___
Asthma?	___	___
Hay fever, hives, other allergies not Previously mentioned?	___	___
High blood pressure?	___	___
Heart murmur, other disorders of the heart?	___	___
Diabetes, thyroid, or other endocrine disorders?	___	___
"Disc" problems, other disorders of muscles, bones, joints?	___	___
Frequent or severe headaches, head injury or Concussion, convulsion?	___	___

Other serious symptoms or illness we should know about?
Please specify:

Women:

Menstrual cycle disorders?	___	___
Any history of vaginal or urinary infections?	___	___

When was you last PAP test? _____

Men:

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 for _____minutes.	___	___
Do you practice safe sex? Please circle: abstinence or use of condoms	___	___
Do you smoke cigarettes? If yes, how long? _____months _____years	___	___
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 drinking?	___	___
-ever been annoyed by people criticizing your drinking?	___	___
-ever felt bad or guilty about your drinking?	___	___
-ever had a morning "Eye Opener" to steady your nerves?	___	___
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 the disease
(Key: M-Mother; F-Father; MGF-Maternal Grandfather; MGM-Maternal Grandmother; PGM-Paternal grandmother PGF-Paternal grandfather; B-Brother; S-Sister)

_____Alcoholism _____Heart disease/heart attack

_____Cancer _____High blood pressure

_____Diabetes _____High cholesterol/triglycerides

_____Mental Illness _____TB

_____Glaucoma _____Other (specify)

DO NOT WRITE BELOW THIS LINE

_____MD, CRNP, PA

Signature of Student Health Care provider reviewing history