University Health Services

HEALTH HISTORY FORM

For Office Use Only

Patient # _____

Patient Name: _____ DOB: ____/____/____

PERSONAL MEDICAL HISTORY:

Yes No	Do you have any allergies (include medications, latex, insect stings or food type)? If yes, please list and reaction type :
Yes No	Do you take regular medications (include birth control, vitamins, supplements, etc)? If yes, please list:
Yes No	Overnight Hospitalizations (non ER). Indicate reason and dates:
Yes No	Past Surgeries. Indicate type of surgery and date:

PERSONAL MEDICAL HISTORY

Do you have or have you ever had any of the following?

If yes, please check ☑ and explain below.

Yes		Yes	
	Alcohol / Drug dependency		Hypoglycemia
	Seasonal Allergies		Kidney Problems
	Anemia / Blood disease		Liver Problems
	ADD/ADHD		Malaria
	Anxiety / Depression		Mononucleosis
	Arthritis		Musculoskeletal Problems
	Asthma		Neurological Problems
	Back Problems		Pregnancy , history of
	Blood Clots (legs, lungs)		Psychological Disorders
	Blood Transfusions		Sexually Transmitted Infection
	Bronchitis / Pneumonia		Strep Throat
	Cancer		Skin Condition
	Concussion / Head Injury		Thyroid Problems
	Diabetes		Tuberculosis / Positive PPD
	Ear Problems		TMJ (jaw problems)
	Eating Disorders		Urinary Tract Infections
	Epilepsy/Seizures		
	Eye / Vision Problems		
	Fractures / History of Injury		
	Gastrointestinal Problems		
	Headaches		
	Heart Problem / Murmur		Other:
	High Blood Pressure		
	High Cholesterol		

FAMILY MEDICAL HISTORY

Does anyone in your immediate family have any of the following conditions? (IE MOTHER, FATHER, SISTER, BROTHER & GRANDPARENTS)

Yes		Indicate which Family Member
	Alcohol / Drug / Substance Dependency	
	Anemia/Blood / Clotting Problem	
	Anxiety/ Depression	
	Arthritis	
	Asthma / Allergies	
	Cancer Specify:	
	Diabetes	
	Eating Disorders	
	Epilepsy, Seizures	
	Gastrointestinal Problems	
	Heart Attack / Stroke	
	High Blood Pressure	
	High Cholesterol	
	Kidney Disease	
	Liver Disease	
	Neurological Problems	
	Psychological Disorders	
	Thyroid Problems	
	Tuberculosis	
	Other:	

IF *YES,* please **explain:** _____

_____

_____

Patient Signature: _____ **Date:**_____

7/11, Rev 10/11, 4/13, 10/14, 5/18,9/22