**HEALTH HISTORY FORM**  
University Health Services

Patient Name: ___________________________  DOB: ___/___/____

### PERSONAL MEDICAL HISTORY:

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

### PERSONAL MEDICAL HISTORY

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

If yes, please check ✓ and explain below.

<table>
<thead>
<tr>
<th>Yes</th>
<th></th>
<th>FAMILY MEDICAL HISTORY</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>Does anyone in your immediate family have any of the following conditions? (IE MOTHER, FATHER, SISTER, BROTHER &amp; GRANDPARENTS)</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>Indicate which Family Member</td>
</tr>
</tbody>
</table>

- Alcohol / Drug dependency
- Hypoglycemia
- Alcohol / Drug / Substance Dependency
- Seasonal Allergies
- Kidney Problems
- Anemia / Blood disease
- Liver Problems
- Anxiety / Depression
- ADD / ADHD
- Malaria
- Arthritis
- Anxiety / Depression
- Mononucleosis
- Musculoskeletal Problems
- Asthma / Allergies
- Arthritis
- Neurological Problems
- Cancer
- Musculoskeletal Problems
- Cancer
- Alcohol / Drug dependency
- Hypoglycemia
- Alcohol / Drug / Substance Dependency

**IF YES, please explain:**

________________________________________________________________________________________________________________________

________________________________________________________________________________________________________________________

________________________________________________________________________________________________________________________

Patient Signature: ___________________________  Date: ___________________________

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