HEALTH HISTORY RECORD

TO THE STUDENT: This is a confidential record. Information you provide will be used solely as an aid in providing health care while you are a student.

Today's date: ______________________________Student ID: ________________________________

Name: ____

Date of Birth: ________________________ E-Mail: _______________________________________

Home Phone #:_____________________ Cell Phone #____________________________________

Please check if any blood relatives have ever had any of the conditions below, and list which relative:

Cancer	
Diabetes	
Allergies	
Asthma	
Heart Disease	
High Blood Pressure	
Stroke	
Kidney Disease	
Stomach Disease	
Epilepsy	
Mental Illness	
Other	

GENERAL MEDICAL HEALTH HISTORY

Have you EVER had or been diagnosed with the following medical conditions?
(PLEASE CHECK ALL THAT APPLY)

Scarlet Fever	
Measles	
German measles	
Mumps	
Diphtheria	
Typhoid	
Poliomyelitis	
SURGERY:	
Appendectomy	
Tonsillectomy	
Hernia Repair	
Other	
Ear, nose, throat problems	
Eye problems	
Gum/tooth problems	
Sinusitis	
Recurrent colds	
Hay fever	
Chicken Pox (Varicella)	

Asthma	
Shortness of Breath	
Chronic cough	
Chest pain	
Spitting up of blood	
Acne/skin problems	
Night sweats	
Thyroid Disease	
Recent weight gain/loss	
Diabetes	
Seizure Disorder/Epilepsy	
Convulsions	
Recurrent Headaches	
Head injury	
Concussion	
Insomnia	
Frequent anxiety	
Frequent depression	
Back problems	

Mononucleosis	
Dizziness, fainting	
Tumor, cyst ,cancer	
High/low blood pressure	
Heart palpitations	
Heart murmur	
Stomach/intestinal problems	
Gallbladder disease	
Diarrhea/constipation	
Hepatitis/liver disease	
Hernia	
Weakness, paralysis	
Urinary Tract infections	
Injury/inflammation of joints	
Ulcer/s	
STDs	
Loss/rupture of an organ	
Other	

ALLERGIES – Please check all that apply:

Medications (please list)	
Insect Bites/Stings	
Foods (which?)	

CURRENT MEDICATIONS: ____

MEDICATION ALLERGIES: ____

WOMEN'S HEALTH HISTORY (FOR FEMALES ONLY)

Is your menstrual cycle regular? **YES** **NO**

Date of last period: _______________

Severe cramps? **YES** **NO**

Excessive flow? **YES** **NO**

Other? ____

	Yes	No
Has your physical activity been restricted during the past five years? (give details below)		
Have you had any illness or injury or been hospitalized other than already noted? (give details below)		
Have you consulted or been treated by any health care provider within the past five years? (other than routine checkups?)		
Have you received treatment or consulting for an emotional problem? (give details below)		

Comments (*use additional paper if needed***):**

____

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____

VISION

Have you ever been to an eye doctor? **YES** **NO**

Date of last visit: ____

Corrected vision: Right 20/ _______ Left 20/ _________

Do you wear glasses now? **YES** **NO**

Do you wear contact lenses? **YES** **NO**

DENTAL

Do you see a Dentist on a regular basis? **YES** **NO**

Date of last visit: ____

____

Signature of Student **Date**

____

Signature of Parent or Guardian (Required if student is under 18) **Date**

Please return to: Student Health Services