



Student Health Services requires a completed Health History on all patients. This information is confidential and used as an aid in providing necessary healthcare while you are a student. This information will only be shared with your permission.

Name: _____

Gender: M F Last _____ First _____ Middle Initial _____
Date of Birth: ____/____/____ Student ID R: _____

Local Address: _____

Street _____ Apt. _____ City/State/Zip _____
Phone #: (____) _____ Marital Status: Married Single

Permanent Address: _____

Street _____ Apt. _____ City/State/Zip _____
Ethnicity: American Indian Asian Black Hispanic White Other _____
Language Preference: English Other _____

EMERGENCY CONTACT

Name: _____ Relationship: Mother Father Other _____

Address: _____ Phone #: (____) _____
Street _____ Apt. _____ City/State/Zip _____

PERSONAL HEALTH HISTORY

Exercise: No Yes Times per week: _____ Height: _____ Weight: _____

Tobacco Use: Never Previous Current Cigarettes/Dip/Chew/Other Amount: _____

Drug Use (social): Never Previous Current Drugs Used: _____

Please circle one answer for each question	0	1	2	3	4	Subtotal
How often did you have a drink containing alcohol in the past year?	never	Monthly or less	2-4 x a month	2-3 x a week	4+ x a week	
How many drinks containing alcohol did you have on a typical day when you were drinking in the past year	1 or 2	3 or 4	5 or 6	7 or 9	10+	
How often did you have six (6) or more drinks on one occasion in the past year?	Never	Less than monthly	Monthly	Weekly	Daily or almost Daily	
<i>We will calculate the totals</i>					Total	

Have you been hospitalized? If yes, please list dates and give a brief explanation: _____

Have you had surgery or a serious injury? If yes, please list surgeries and/or injuries with dates: _____

Do you take any over-the-counter or prescription medications regularly? If yes, please list with dosage: _____

Do you have any allergies to medications? If yes, please list and describe the reaction: _____

FOR WOMEN ONLY

Are you or could you possibly be pregnant? Yes: No: What Contraception or cycle regulation methods do you use? (mark **All** that Apply)

Condoms: Depo-Provera: Diaphragm: Implanon: IUD: Nuva Ring: Pills:

Other: _____

I HERBY CERTIFY THAT THE ABOVE HISTORY IS COMPLETE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

Student Signature

Date