

## University Health Services Medical History Form

Date: \_\_\_\_\_ Completed by: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Sex: F \_\_\_ M \_\_\_

Address: \_\_\_\_\_ Phone #: (C) \_\_\_\_\_ Marital Status:  
S M D  
\_\_\_\_\_  
(H) \_\_\_\_\_

### Past History of Medical Illnesses:

Please mark "yes" or "no" if you have had a past history of the following:

High blood pressure	yes ___ no ___	Diabetes	yes ___ no ___	Arthritis	yes ___ no ___
Heart disease	yes ___ no ___	Thyroid disorder	yes ___ no ___	Headaches	yes ___ no ___
Lung trouble	yes ___ no ___	Gout	yes ___ no ___	Epilepsy	yes ___ no ___
Circulation problems	yes ___ no ___	Anemia	yes ___ no ___	Strokes	yes ___ no ___
Eye problems	yes ___ no ___	Asthma	yes ___ no ___	Allergic illnesses	yes ___ no ___
Cancer	yes ___ no ___	Hepatitis	yes ___ no ___	Ulcer	yes ___ no ___
Hiatal hernia	yes ___ no ___	Kidney disease	yes ___ no ___	Pelvic disease	yes ___ no ___
Skin disease	yes ___ no ___	Prostate problems	yes ___ no ___	Bleeding/clotting disorders	yes ___ no ___
Infections	yes ___ no ___	HIV	yes ___ no ___	TB	yes ___ no ___
Neurological disease	yes ___ no ___	Other:	_____		

**Please list all medication which you are currently taking, including over-the-counter and herbs.**

Medication	Dose	How often?	Reason for the Medication?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Please list any surgeries or serious injuries (e.g. auto accidents) and their dates:** \_\_\_\_\_

**Please list any hospital admissions, their reason (e.g. childbirth) and dates.** \_\_\_\_\_

**Social History:** Living arrangement? \_\_\_\_\_ Who lives with you? \_\_\_\_\_

Occupation? \_\_\_\_\_ Education Completed? \_\_\_\_\_

Money situation? Ok \_\_\_ Limited \_\_\_ Primary language spoken at home? \_\_\_\_\_

Tobacco use? Yes \_\_\_ No \_\_\_ What type? \_\_\_\_\_ How often? \_\_\_\_\_ Packs per day \_\_\_\_\_ Desire to quit? \_\_\_\_\_

Alcohol use? Yes \_\_\_ No \_\_\_ What type? \_\_\_\_\_ How often? \_\_\_\_\_ Amount? \_\_\_\_\_

Illicit drug use? Yes \_\_\_ No \_\_\_ What type? \_\_\_\_\_ How often? \_\_\_\_\_

Sexual history: Currently active Yes \_\_\_ No \_\_\_ # partners in the last year \_\_\_\_\_ Preference Male \_\_\_ Female \_\_\_ Both \_\_\_

**Please list all immunizations that you have had.**

Varicella Yes \_\_\_ No \_\_\_ Chicken Pox Yes \_\_\_ No \_\_\_ MMR Yes \_\_\_ No \_\_\_

Tetanus Yes \_\_\_ No \_\_\_ Last Booster \_\_\_\_\_ Pneumonia vaccine? Once \_\_\_ Twice \_\_\_ Never \_\_\_

Meningitis Yes \_\_\_ No \_\_\_ Influenza vaccine? Yes \_\_\_ No \_\_\_ Yearly \_\_\_\_\_

When was your last TB skin test? \_\_\_\_\_ Was it positive? \_\_\_ or negative? \_\_\_\_\_

Hepatitis? Yes \_\_\_ No \_\_\_ BCG? Yes \_\_\_ No \_\_\_

Have you been exposed to any environmental hazards? Yes \_\_\_ No \_\_\_ If yes, what and when? \_\_\_\_\_

Has your home been tested for radon? Yes \_\_\_ No \_\_\_ Any travel/living outside the USA? \_\_\_\_\_

Have you given directions for health care if you become unable to speak for yourself later? Yes \_\_\_ No \_\_\_

\*\*Do you have a living will? Yes \_\_\_ No \_\_\_ \*\*Do you have a Durable Power of Attorney? Yes \_\_\_ No \_\_\_

**\*\*If you answered "Yes" to either question, JCAHO requires that you provide a copy for your medical record.**

