IUPUI Campus Health
HEALTH HISTORY FORM
STUDENTS

NAME: _____ **DOB:** _____ **TODAY's Date:** _____
(Last, First, MI) (mo/day/yr)

Do you work? No Yes-how many hours per week?_____ What type of work?_____

MEDICATIONS you are currently taking (include vitamins, herbs, supplements, birth control pills, etc):

NAME	DOSE	Date Started

ALLERGIES (including drugs, dust, pollen, grasses, eggs, feathers, foods, latex, or other?) NONE _____

ALLERGY	REACTION	DATE of REACTION

Please list serious illnesses, injuries, any surgeries and hospitalizations, the year and the provider at the time

Year	Illnesses, Injuries, Surgeries and Hospitalizations	Provider

FAMILY HISTORY

MOTHER ___ Living __ Deceased ___Age at death				**FATHER** ___Living __ Deceased __ Age at death			
Alcoholism	___	Hypertension	___	Alcoholism	___	Hypertension	___
Anxiety	___	Kidney Disease	___	Anxiety	___	Kidney Disease	___
Arthritis	___	Liver Disease	___	Arthritis	___	Liver Disease	___
Asthma	___	Obesity	___	Asthma	___	Obesity	___
Bipolar	___	Seizures	___	Bipolar	___	Seizures	___
Blood clot	___	Stomach Trouble	___	Blood clot	___	Stomach Trouble	___
Cancer	___	Stroke	___	Cancer	___	Stroke	___
Depression	___	Thyroid disease	___	Depression	___	Thyroid disease	___
Diabetes	___	Tuberculosis	___	Diabetes	___	Tuberculosis	___
Eczema/Psoriasis	___	Ulcer	___	Eczema/Psoriasis	___	Ulcer	___
Heart Disease	___	Other _____		Heart Disease	___	Other _____	

Please turn over and complete the other side

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<u>YOUR</u> HISTORY – Please check if <u>you</u> have ever had any of the following:

__ Acid Reflux
__ Alcohol/Drug Dependence
__ Anemia
__ Anxiety
__ Asthma/Hay Fever
__ Bipolar Disorder
__ Bleeding Disorder
__ Blood Clots (VTE, PE)
__ Chest Pain/Pressure
__ Chicken Pox
__ Chronic Cough
__ Chronic Fatigue
__ Depression
__ Diabetes
__ Dizziness/Fainting
__ Eczema/Psoriasis
__ Epilepsy
__ Gallbladder Trouble
__ Gluten Sensitivity
__ Gum/Tooth Trouble
__ Headaches
__ Hearing/Vision Disorder
__ Heart Murmur
__ Heart Palpitations
__ Hepatitis
__ Hernia
__ Hives
__ Insomnia
__ Irregular Periods
__ Irritable Bowel Syndrome
__ Kidney Stones
__ Lactose Intolerance
__ Malaria
__ Measles
__ Mononucleosis
__ Musculoskeletal Disorder
__ Nose/Throat Trouble
__ Personality Disorder
__ Poliomyelitis
__ Pregnancy
__ Recent Weight Gain/Loss
__ Rheumatic Fever
__ Scarlet Fever
__ Seizures
__ STD
__ Shortness of Breath
__ Shoulder Dislocation
__ Sinusitis
__ Sleep Disorder
__ Thyroid Disease
__ Tuberculosis
__ Tumor/Cancer/Cyst

Other _____

Please circle all that apply

Do you use tobacco products? NO

YES Type: Chew Cigarette Cigar e-cigarette

Do you drink alcohol? NO DAILY WEEKLY MONTHLY

Type: Beer Wine Hard liquor

If NO: Have you used tobacco products regularly in the past?

No Yes How long ago? _____days months years