**IUPUI Campus Health HEALTH HISTORY FORM**

NAME:

DOB:

JOB TITLE:

**(Last, First, MI) (mo/day/yr)**

ADDRESS:

Phone – Home/Cell: Work:

MEDICATIONS you are currently taking (including vitamins, herbs, 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

**FATHER** Living Deceased Age at death **MOTHER** 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 |  |
| Cancer |  | Seizures |  | Cancer | \_ | Seizures |  |
| Depression |  | Stomach Trouble | \_ | Depression | \_ | Stomach Trouble |  |
| Diabetes |  | Tuberculosis |  | Diabetes | \_ | Tuberculosis |  |

Heart Disease Other \_ Heart Disease \_ Other

**Please turn over and complete the other side**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **IUPUI Campus Health HEALTH HISTORY FORM** | | | | | | |
| **YOUR HISTORY – Please check if you have ever had any of the following:**  Acid Reflux Diabetes Hives Pregnancy  Alcohol/Drug Dependence Dizziness/Fainting Insomnia Recent Weight Gain/Loss  Anemia Eczema/Psoriasis Irregular Periods Rheumatic Fever  Anxiety Epilepsy Irritable Bowel Syndrome Scarlet Fever  Asthma/Hay Fever Gallbladder Trouble Kidney Stones Seizures  Bipolar Disorder Gluten Sensitivity Lactose Intolerance STD  Bleeding Disorder Gum/Tooth Trouble Malaria Shortness of Breath  Blood Clots (VTE, PE) Headaches Measles Shoulder Dislocation  Chest Pain/Pressure Hearing/Vision Disorder Mononucleosis Sinusitis  Chicken Pox Heart Murmur Musculoskeletal Disorder Sleep Disorder  Chronic Cough Heart Palpitations Nose/Throat Trouble Thyroid Disease  Chronic Fatigue Hepatitis Personality Disorder Tuberculosis  Depression Hernia Poliomyelitis Tumor/Cancer/Cyst  Other | | | | | | |
|  | | | | | | |
| **Do you use tobacco products?** NO Type: Chew Cigarette | YES  Cigar | | **Do you drink alcohol?**  Type: Beer | | NO  Wine | DAILY WEEKLY MONTHLY  Hard liquor |
|  | | | | | | |
| **Are you aware of any injury or illness that may interfere with your job or may require accommodations on your job such as:** | | | | | | |
|  | | **NO** | **YES** | **If yes, give brief explanation** | | |
| **Sensitivity to chemicals, dust, sunlight, etc?** | |  |  |  | | |
| **Inability to perform certain motions?** | |  |  |  | | |
| **Inability to assume certain positions?** | |  |  |  | | |
| **Other medical issue? (list below)** | |  |  |  | | |
|  | |  |  |  | | |
| **I have carefully read and completed the foregoing information in this Health History Form. I certify that my answers and explanations are true to the best of my knowledge and belief.**  **Signature Date** | | | | | | |