**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/CystOther  |
|  |
| **Do you use tobacco products?** NO Type: Chew Cigarette | YESCigar | **Do you drink alcohol?**Type: Beer | NOWine | DAILY WEEKLY MONTHLYHard 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**  |