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
__ ADHD
__ 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