LAKE SUPERIOR
STATE UNIVERSITY
Health CARE Center

Health History Questionnaire

PLEASE USE INK

The purpose of this questionnaire is to aid us in providing quality health care. Please complete the questions as accurately as possible (print legibly). ***This questionnaire and your entire clinical record is strictly confidential and will not be released to anyone without your written consent/signature.***

Name: ______________________________ Today's Date: ______________
Last First M.I.

Date of Birth: ____-____-____ Sex: ❑ M ❑ F Student ID # ______________
Month Day Year

Parent's Name *(if child)*: ______________

CURRENT MEDICATIONS: Please list any *prescription* ***and*** *over-the-counter medications* (including herbal remedies and nutritional supplements) you are currently taking. Include name, how often, how much, and how long you have been taking them. **If none, state none.** *(Females: include your oral contraceptives/birth control pills, etc.)*

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DRUG/MEDICATION ALLERGIES: Please list all *prescription* and/or *over-the-counter* allergies. Also state the *type of allergic reaction* (i.e., skin — rash, hives; respiratory — difficulty breathing, etc.) **If none, state none.**

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OTHER ALLERGIES: Please list any other environmental, food, or product allergies (i.e., latex) you may have and the type of reaction. **If none, state none.**

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Are you disabled and/or handicapped in any way? ❑ Yes ❑ No If yes, please explain:

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Have you ever been hospitalized? ❑ Yes ❑ No If yes, please give date(s) and reason(s):

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Have you ever had surgery? ❑ Yes ❑ No If yes, please give type(s) and date(s):

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Do you smoke cigarettes? ❑ Yes ❑ No If yes, how many per day? __________

Do you chew tobacco? ❑ Yes ❑ No If yes, how much per day? __________

Do you drink alcohol? ❑ Yes ❑ No If yes, type/amount: ______________

Do you use street drugs? ❑ Yes ❑ No If yes, type/amount: ______________

Are you satisfied with your weight? ❑ Yes ❑ No (please explain) ______________

Females: Last gynecological exam (Pap) and results: ______________

Males/Females: Last health exam/results: ______________

Last vision exam/results: ______________ Last dental exam/results: ______________

Please complete reverse side.

PERSONAL MEDICAL HISTORY

Check the appropriate space for any illness that you have had in the past or have now.

- ❑ Alcoholism
- ❑ Anemia
- ❑ Asthma
- ❑ Bleeding tendency
- ❑ Bronchitis, chronic
- ❑ Cancer
- ❑ Colitis, spastic/ulcerative
- ❑ Colon Polyps
- ❑ Depression, anxiety
- ❑ Diabetes mellitus
- ❑ Ear infections, frequent
- ❑ Eating disorder (specify) ______________________________
- ❑ Emphysema
- ❑ Epilepsy — seizure disorder
- ❑ Fibrocystic breasts
- ❑ Gallbladder problems
- ❑ Gout
- ❑ Gynecological/menstrual problems; pelvic infection
- ❑ Headaches (specify type if possible) ______________________________
- ❑ Heart murmur
- ❑ Heart problem other than murmur; specify: ______________________________ ______________________________
- ❑ Hepatitis
- ❑ Hereditary or congenital disorder
- ❑ Herpes, genital
- ❑ High blood fats; i.e., cholesterol, triglycerides
- ❑ High blood pressure
- ❑ Hypoglycemia
- ❑ Kidney infection
- ❑ Kidney stones
- ❑ Male genital problems; i.e. prostatitis, urethritis, tumor
- ❑ Meningitis
- ❑ Mental illness other than depression
- ❑ Mononucleosis
- ❑ Obesity (more than 20% over ideal weight
- ❑ Phlebitis
- ❑ Pneumonia
- ❑ Rheumatic fever
- ❑ Rheumatoid arthritis
- ❑ Sexually transmitted disease
- ❑ Stroke
- ❑ Thyroid disorder
- ❑ Tuberculosis
- ❑ Venereal warts
- ❑ Ulcers
- ❑ Other; please specify ______________ ______________________________

VACCINATION HISTORY

Vaccine		Date
Last Td (tetanus) booster		
MMR	Dose 1	
	Dose 2	
Varicella (Chicken Pox)		
Meningitis		
Hepatitis B	Dose 1	
	Dose 2	
	Dose 3	
Other ______________ ______________ ______________		

FAMILY MEDICAL HISTORY

Check the appropriate space for any illness that has occurred in a blood relative (parents, grandparents, brothers, sisters and children).

- ❑ Alcoholism
- ❑ Anemia
- ❑ Bleeding tendency
- ❑ Cancer
- ❑ Colon Polyps
- ❑ Diabetes mellitus
- ❑ Heart problems
- ❑ High blood pressure
- ❑ Mental illness
- ❑ Migraine headaches
- ❑ Obesity (more than 20% over ideal weight)
- ❑ Rheumatoid arthritis
- ❑ Stroke
- ❑ Suicide
- ❑ Thyroid disorder
- ❑ Tuberculosis
- ❑ Ulcers
- ❑ Other; please specify: ______________________________ ______________________________

Signature ______________________________ Date ______________________

Adult Patient ________ *Parent* ________ *Guardian* ________

Updated 3/19/09