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: _____ (Last / First / M.I.) Today's Date: _____

Date of Birth: ___ - ___ - ___ (Month - Day - Year) Sex: ❑ M ❑ F Student ID # _____

Parent's Name *(if child)*: _____ Social Security # _____

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:

_____

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

_____

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

_____

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 _____

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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* _____