

FLORIDA ATLANTIC UNIVERSITY - STUDENT HEALTH SERVICES

HEALTH HISTORY

Name:	Student ID/Z#	Date / /
Birth Date / /	Sex M F TG	Marital Status S M D W
Ethnicity (please check one) <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Black/African American <input type="checkbox"/> Hispanic <input type="checkbox"/> White <input type="checkbox"/> Prefer Not to Answer		
Local Address (City, State, Zip Code)		
Cell phone #	Active duty service member? Yes No	
E-mail address:	Veteran of the U.S. Military? Yes No	
Type of Insurance:		

PAST MEDICAL HISTORY

ALLERGIES: (Include drug, food and environmental)

CURRENT MEDICATIONS: (include contraceptives, supplements, and over the counter preparations, include dose and frequency)

Do you now have or have you ever been treated for:	Yes	No	If yes, Date	Do you now have or have you ever been treated for:	Yes	No	If yes, Date
Blood diseases, including anemia, clots, strokes or varicose veins				Gastric – intestinal problems, including GERD, gallbladder, ulcer, Crohn’s disease, irritable bowel syndrome, or liver disease			
Cancer, cysts or tumors				Heart problems, high cholesterol, or high blood pressure			
Respiratory or pulmonary problems, including asthma or bronchitis				Skin problems, including infections, eczema, or psoriasis			
Bladder/kidney or any other urinary problems				Immune disease problems, such as lupus or rheumatoid arthritis			
Diabetes, hypoglycemia or thyroid disease				Infections, including tuberculosis, malaria, hepatitis, HIV, or rheumatic fever.			
Ear, nose or throat problems, including sinusitis, ear infections, or strep throat				Muscular or skeletal problems, including arthritis, fractures, or neck and back problems			
Genital problems, including gynecological, prostate, testicular or sexual transmitted infections				Neurologic problems, including epilepsy, seizures, head injury, headaches, migraines, dizziness, passing out, or vertigo			
Eating disorders, including anorexia, bulimia, or overeating				Psychological problems, including depression or anxiety			
Alcohol/drug dependence							

Other injuries or illnesses:

Explain any yes answers:

Past surgeries: Yes No If yes, list dates and type of surgery

Past hospitalizations: Yes No If yes, list dates and reason for hospitalization

GYNECOLOGICAL HISTORY (women only)

Date of last menstrual period: Is it regular? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of last pap smear : Was it normal? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever had an abnormal pap smear? <input type="checkbox"/> Yes <input type="checkbox"/> No	Age Menstrual Period Started:	Date of last breast exam: Was it normal? <input type="checkbox"/> Yes <input type="checkbox"/> No
Pregnancies? <input type="checkbox"/> Yes <input type="checkbox"/> No Dates:	Live births? <input type="checkbox"/> Yes <input type="checkbox"/> No Dates:	Miscarriages? <input type="checkbox"/> Yes <input type="checkbox"/> No Dates:	Abortions? <input type="checkbox"/> Yes <input type="checkbox"/> No Dates:

FAMILY HEALTH HISTORY

Please list the following family health problems below: Blood clotting problems; cancers; heart disease or heart attack; high blood pressure; stroke; diabetes (sugar); thyroid problems; liver problems, substance and alcohol abuse, and psychiatric problems,

	Age	Health problem(s)	Deceased/Living (D/L)
Mother			
Father			
Brothers/Sisters			
Brothers/Sisters			
Brothers/Sisters			
Other blood relative			

SOCIAL HISTORY

Do you smoke/use tobacco products? <input type="checkbox"/> Yes <input type="checkbox"/> No What product(s)? _____ How much per day? _____	Are you sexually active? <input type="checkbox"/> Yes <input type="checkbox"/> No Age at time of first intercourse: _____
Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No How much? _____	Have you had more than one sexual partner in past 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No male / female / both
Do you use recreational drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No	Birth control? <input type="checkbox"/> Yes <input type="checkbox"/> No Type _____
Do you want to hurt yourself or anyone else? <input type="checkbox"/> Yes <input type="checkbox"/> No	Condoms used? <input type="checkbox"/> Yes <input type="checkbox"/> No % of time used _____
Do you feel safe where you live? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does someone you know make you feel unsafe? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you felt sad or down in the past 2 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No	

In Case of Emergency Notify:

Name _____	Relationship _____
Address _____	
Home Phone () _____	Cell/Work Phone () _____

Release to Treat

The previous medical history responses are true and correct to the best of my knowledge. I hereby authorize medical, dental, and surgical care, including examinations, treatment, immunizations, and other medical procedures, within the discretion of the student health services personnel.

In the event of serious disease, injury, or need for major surgery, I hereby consent to emergency treatment necessary to help preserve life or health. If the student is under age 18, it is understood that all reasonable efforts will be made to contact the parent or guardian, should an emergency occur.

I hereby authorize Student Health Services to use the above stated health information for any treatment or care. All information will be kept confidential.

Signature of Student _____	date _____
Signature of parent or guardian (if student is under 18) _____	date _____
Student Health Services Staff Signature _____	date _____