FAU STUDENT HEALTH SERVICES
HEALTH HISTORY FORM

Name: Student ID/Z# Date / /

Local Address (City, State, Zip Code)

Cell phone # ( ) Type of insurance: _____

Birth Date / / Relationship status:

Sex assigned at birth: ☐ Male ☐ Female ☐ Anything else _____ Preferred name: _____

Gender Identity: (check all that apply)

☐ woman ☐ man ☐ genderqueer ☐ trans woman ☐ trans man ☐ prefer not to say ☐ self identity_____

What pronouns do you use?

☐ she/her/hers ☐ he/him/his ☐ they/them/their ☐ Anything else _____

Ethnicity (please check one): ☐ American Indian/Alaskan Native ☐ White ☐ Hispanic ☐ Asian/Pacific Islander ☐ Black/African American ☐ Prefer not to answer

Are you? Please Circle

Active duty service member?	☐ Yes ☐ No
Veteran of the U.S. Military?	☐ Yes ☐ No
Dual-enrolled high school student?	☐ Yes ☐ No
FAU staff or faculty member taking courses through Employee Educational Scholarship Program?	☐ Yes ☐ No
FAU staff or faculty member taking courses, but not through Employee Educational Scholarship Program?	☐ Yes ☐ No

PAST MEDICAL HISTORY

ALLERGIES: (Include drug, food and environmental allergies)

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: e.g., Reflux, Crohn's, 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			
Ear, nose or throat problems, including sinusitis, ear infections, or strep throat				Muscle/skeletal: including arthritis, fractures, or neck and back problems			
Genital problems, e.g., gynecological, testicular or sexual transmitted infections				Neurologic problems: seizures, head injury, headaches, dizziness, passing out			
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 (if applicable)

Age of first menstrual period: _____ Date of last menstrual period: _____ Is it regular? ☐ Yes ☐ No	Date of last pap smear: _____ Was it normal? ☐ Yes ☐ No Have you ever had an abnormal pap smear? ☐ Yes ☐ No	Did you receive the HPV vaccine? ☐ Yes ☐ No	How many pregnancies have you had? _____ How many live births? _____

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)
Father			
Mother			
Brothers/Sisters			
Other blood relative			

SOCIAL HISTORY

Do you smoke/use tobacco products? ☐ Yes ☐ No How much per day?_____	Are you sexually active? ☐ Yes ☐ No Age at time of first intercourse:_____
Do you drink alcohol? ☐ Yes ☐ No How much?_____	Have you had more than one sexual partner in past 6 months? ☐ Yes ☐ No male / female / both
Do you use recreational drugs? ☐ Yes ☐ No	Birth control? ☐ Yes ☐ No Type_____
Do you want to hurt yourself or anyone else? ☐ Yes ☐ No	Condoms used? ☐ Yes ☐ No % of time used_____
Do you feel safe where you live? ☐ Yes ☐ No	Does someone you know make you feel unsafe? ☐ Yes ☐ No

In Case of Emergency Notify

Name

Relationship

Address

Home Phone ( ) Cell/Work Phone ( )

The previous medical history responses are true and correct to the best of my knowledge.

_____ __/____/_____

Signature of Student **date**

_____/_____/_____

Student Health Services Staff Signature date