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)	☐ American Indian/Alaskan Native	☐ White	
	☐ Hispanic	☐ Black/African American	
	☐ Asian/Pacific Islander	☐ Prefer Not to Answer	
Local Address (City, State, Zip Code)			
Cell phone #			
E-mail address:			
Type of Insurance:			

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)

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 (if applicable)

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	Age Menstrual Period Started:	Date of last breast exam: Was it normal? ☐ Yes ☐ No
Pregnancies? ☐ Yes ☐ No Dates:	Live births? ☐ Yes ☐ No Dates:	Miscarriages? ☐ Yes ☐ No Dates:	Abortions? ☐ Yes ☐ 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? ☐ Yes ☐ No What product(s)? 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
Have you felt sad or down in the past 2 weeks? ☐ Yes ☐ 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