

HEALTH AND WELLNESS CENTER

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PLEASE PRINT PATIENT HISTORY					
LAST NAME	FIRST NAME		MIDDLE INITIAL		
DATE OF BIRTH STUDENT ID #		SEX MA	ALE [] FEMALE []		
	FAMILY MED	DICAL HISTORY			
Age Current Health Cause	le) Any family history of: Yes No				
Age Current Health Cause of Death (if applicable) Father		D. 1	Diabetes		
Mother		Heart	Disease		
	Cancer				
	Drug Abus				
Sibling		,,	please explain		
		EDICAL HISTORY			
	Y N		1	Υ	N
Eating Disorder		Rubella			
Alcohol/Drug Abuse		Hepatitis B Disease			
Anxiety/Depression/Mental Illness/ADHD		High Blood Pressure			
Asthma		HIV/AIDS			
Cancer		Measles			
Cardiac Condition/Heart Murmur		Mononucleosis			
Chicken Pox		Mumps			
Convulsions/Seizure Disorder		Rheumatic Fever			
Dental Problems		Sickle Cell Anemia			
Diabetes		Thyroid Disorder			
Kidney Problems		Tuberculosis			
Gastrointestinal Problems		Other			
Head injury with loss of consciousness					
		<u> </u>			1.
ALLERGIES			1.0 Tl	Y	N
			Life Threatening? Life Threatening?	+	
Insect (List Insect) Life Threatening?				+	
Other (List) Life Threatening					
PRIOR HOSPITALIZATIONS/SURGERY DATE HEALTH BEHAVIORS				+	
Previous Surgery/Hospitalization/Injury? Explain		Do you smoke? Y N How much? Number of years?			
		Do you drink alcohol? Y N How much? How often?			
Physical Impairment? Explain		Do you drink caffeine? Y N How much?			
		Do you engage in recreational drug use? Y N Do you engage in IV drug use? Y N			
Emotional Problems Requiring Treatment? Explain		Regular exercise? Y N			
		Use seat belts? Y N			
Current Medications? List		Use bike helmets? Y N			
		Take vitamins/supplements? Y N		JUI	N2015