IUPUI Campus Health
HEALTH HISTORY FORM
STUDENTS

NAME: ______________________________ **DOB:** __________ **TODAY's Date:** ______________________
(Last, First, MI) (mo/day/yr)

Do you work? No Yes-how many hours per week?______ What type of work?_________________________

MEDICATIONS you are currently taking (include vitamins, herbs, supplements, birth control pills, etc):

NAME	DOSE	Date Started
_____________________________	________________________	________________________
_____________________________	________________________	________________________
_____________________________	________________________	________________________
_____________________________	________________________	________________________
_____________________________	________________________	________________________

ALLERGIES (including drugs, dust, pollen, grasses, eggs, feathers, foods, latex, or other?) NONE ______

ALLERGY	REACTION	DATE of REACTION
______________________________	________________________	________________________
______________________________	________________________	________________________
______________________________	________________________	________________________

Please list serious illnesses, injuries, any surgeries and hospitalizations, the year and the provider at the time

Year	Illnesses, Injuries, Surgeries and Hospitalizations	Provider
_________	____	______________________
_________	____	______________________
_________	____	______________________

FAMILY HISTORY

MOTHER ___ Living __ Deceased ___Age at death

Alcoholism	___	Hypertension	___
Anxiety	___	Kidney Disease	___
Arthritis	___	Liver Disease	___
Asthma	___	Obesity	___
Bipolar	___	Seizures	___
Blood clot	___	Stomach Trouble	___
Cancer	___	Stroke	___
Depression	___	Thyroid disease	___
Diabetes	___	Tuberculosis	___
Eczema/Psoriasis	___	Ulcer	___
Heart Disease	___	Other ________________	

FATHER ___Living __ Deceased __ Age at death

Alcoholism	___	Hypertension	___
Anxiety	___	Kidney Disease	___
Arthritis	___	Liver Disease	___
Asthma	___	Obesity	___
Bipolar	___	Seizures	___
Blood clot	___	Stomach Trouble	___
Cancer	___	Stroke	___
Depression	___	Thyroid disease	___
Diabetes	___	Tuberculosis	___
Eczema/Psoriasis	___	Ulcer	___
Heart Disease	___	Other ____________________	

Please turn over and complete the other side

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YOUR HISTORY – Please check if you have ever had any of the following:

__ Acid Reflux	__ Diabetes	__ Hives	__ Pregnancy
__ Alcohol/Drug Dependence	__ Dizziness/Fainting	__ Insomnia	__ Recent Weight Gain/Loss
__ Anemia	__ Eczema/Psoriasis	__ Irregular Periods	__ Rheumatic Fever
__ Anxiety	__ Epilepsy	__ Irritable Bowel Syndrome	__ Scarlet Fever
__ Asthma/Hay Fever	__ Gallbladder Trouble	__ Kidney Stones	__ Seizures
__ Bipolar Disorder	__ Gluten Sensitivity	__ Lactose Intolerance	__ STD
__ Bleeding Disorder	__ Gum/Tooth Trouble	__ Malaria	__ Shortness of Breath
__ Blood Clots (VTE, PE)	__ Headaches	__ Measles	__ Shoulder Dislocation
__ Chest Pain/Pressure	__ Hearing/Vision Disorder	__ Mononucleosis	__ Sinusitis
__ Chicken Pox	__ Heart Murmur	__ Musculoskeletal Disorder	__ Sleep Disorder
__ Chronic Cough	__ Heart Palpitations	__ Nose/Throat Trouble	__ Thyroid Disease
__ Chronic Fatigue	__ Hepatitis	__ Personality Disorder	__ Tuberculosis
__ Depression	__ Hernia	__ Poliomyelitis	__ Tumor/Cancer/Cyst

Other ____

Please circle all that apply

Do you use tobacco products? NO

YES Type: Chew Cigarette Cigar e-cigarette

Do you drink alcohol? NO DAILY WEEKLY MONTHLY

Type: Beer Wine Hard liquor

If NO: Have you used tobacco products regularly in the past?

No Yes How long ago? _________days months years

Revised 4/16/2015