HEALTH HISTORY FORM

UNION UNIVERSITY
HEALTH SERVICES

NAME:		
DATE OF BIRTH:		TODAY'S DATE:

YOUR MEDICAL HISTORY

Please indicate if YOU have a history of the following:

	Alcohol Abuse		Growth / Development Disorder		Migraines
	Anemia		Hearing Impairment		Osteoporosis
	Anesthetic Complication		Heart Attack		Prostate Cancer
	Anxiety Disorder		Heart Disease		Rectal Cancer
	Arthritis		Heart Pain/Angina		Reflux/GERD
	Asthma		Hepatitis A		Seizures/Convulsions
	Autoimmune Problems		Hepatitis B		Severe Allergy
	Birth Defects		Hepatitis C		Sexually Transmitted Disease
	Bladder Problems		High Blood Pressure		Skin Cancer
	Bleeding Disease		High Cholesterol		Stroke/CVA of the Brain
	Blood Clots		HIV		Suicide Attempt
	Blood Transfusion(s)		Hives		Thyroid Problems
	Bowel Disease		Kidney Disease		Ulcer
	Breast Cancer		Liver Cancer		Visual Impairment
	Cervical Cancer		Liver Disease		Other Disease, Cancer, or Significant Medical Illness
	Colon Cancer		Lung Cancer		
	Depression		Lung/Respiratory Disease		NONE of the Above
	Diabetes		Mental Illness		

PERSONAL SURGICAL HISTORY: Have you ever had any of the following surgeries? (Check if yes)

	Adrenal Gland Surgery		Colon Surgery		Kidney Surgery
	Appendectomy		Coronary Artery Bypass Graft		Neck Surgery
	Bariatric Surgery		Esophagus Surgery		Prostrate Surgery
	Bladder Surgery		Gastric Bypass Surgery		Small Intestine Surgery
	Breast Surgery		Hemorrhoid Surgery		Spine Surgery
	Cesarean Section		Hernia Repair		Thyroid Surgery
	Cholecystectomy/Gallbladder		Hysterectomy		Tonsil Surgery

List your prescribed drugs including any over-the-counter medications. Don't forget to list medications such as vitamins, supplements, and inhalers.

Name of Drug	Strength	Frequency Taken
Current Method of Birth Control: (Examples: oral pills, injections, patch, condoms, IUD, abstinence, none, etc.)		

ALLERGIES TO MEDICATIONS

Name the Drug(s)	Reaction You Had

FAMILY MEDICAL HISTORY

NAME: _____

DATE: _____

Please indicate if YOUR FAMILY has a history of the following: (***ONLY*** *include parents, grandparents, siblings, and children)*

	I am adopted and do not know biological family history				
	Family History Unknown		Colon Cancer		Migraines
	Alcohol Abuse		Depression		Osteoporosis
	Anemia		Diabetes		Other Cancer
	Anesthetic Complication		Heart Disease		Rectal Cancer
	Arthritis		High Blood Pressure		Seizures/Convulsions
	Asthma		High Cholesterol		Severe Allergy
	Bladder Problems		Kidney Disease		Stroke/CVA of the Brain
	Bleeding Disease		Leukemia		Thyroid Problems
	Breast Cancer		Lung/Respiratory Disease		NONE of the Above

	Mother, Grandmother, or Sister developed heart disease before the age of 65.
	Father, Grandfather, or Brother developed heart disease before the age of 65.

SUBSTANCE USE

DRUG CATEGORY (circle each substance used)	Age when you first used this:	How much & how often you use this?	How many years did you use this?	When did you last use this?	Do you currently use this?
ALCOHOL					YES □ NO □
CANNABIS: Marijuana, hashish, hash oil					YES □ NO □
STIMULANTS: Methamphetamie – speed, ice, crank					YES □ NO □
AMPHETAMINES/OTHER STIMULANTS: Ritalin, Benzedrine, Dexedrine, Adderall					YES □ NO □
BENZODIAZEPHINES/TRANQULIZERS: Valium, Librium, Halcion, Xanax, Diazepam, "Roofies"					YES □ NO □
SEDATIVES/HYPNOTICS/BARBITUARATES: Amytal, Seconal, Dalmane, Quaalude, Phenobarbital					YES □ NO □
HEROIN					YES □ NO □
STREET OR ILLICIT METHADONE					YES □ NO □
OTHER OPIOIDS: Tylenol #2, & #3, 282's, 292's, Percodan, Percocet, Opium, Morphine, Demerol, Dilaudid					YES □ NO □
HALLUCINOGENS: LSD, PCP, STP, MDA, DAT, mescaline, peyote, mushrooms, ecstasy (MDMA), nitrous oxide					YES □ NO □
INHALANTS: Glue, gasoline, aerosols, paint thinner, poppers, rush, locker room, vaping					YES □ NO □
TOBACCO Cigarettes, cigars, dip, chew, vaping					YES □ NO □