

**HEALTH HISTORY FORM**

Student Health Services

Division of Student Affairs – Texas A&M University

PERSONAL INFORMATIONName: _____ Sex: M F Age: _____ Date of Birth: _____
Last First M.I.

Social Security Number or TAMU ID _____ Marital Status: _____ Race (opt.): _____

Current Address: _____ Phone #: (_____)
Street/P.O. Box City, State, ZipPermanent Address: _____ Phone #: (_____)
Street/P.O. Box City, State, Zip**EMERGENCY CONTACT INFORMATION**

Name: _____ Relationship to you: _____

Phone Number: (_____) _____

MEDICINES YOU ARE TAKING

(List medicines, birth control pills, or vitamins you take with or without a prescription)

_____**DRUG AND/OR OTHER ALLERGIES**

(List those you are allergic to)

_____**HEALTH CARE PROVIDERS**

Name of Family Health Care Provider: _____ Phone #: (_____)

When was your last complete physical? _____ Please list below anyone else you may have received healthcare from in the past:

Year	Name of Doctor or Other Provider	Location City, State	Primary Problems Cared for
_____	_____	_____	_____
_____	_____	_____	_____

Authorization for Treatment and Statement of Financial Responsibility:

- I hereby certify that the information provided above and the health history information on the reverse side of this form is complete to the best of my knowledge.
- I do hereby give permission for the TAMU Student Health Service professional medical staff to provide medical services to help maintain my good health for as long as I am a student at Texas A&M University.
- I understand and give consent for my protected health information to be used to carry out treatment, to be sent to insurance carriers for payment, or for other health care operations.
- I understand that I am responsible for charges incurred during my visit.

IF YOU ARE UNDER 18 YEARS OF AGE, YOUR LEGAL GUARDIAN MUST SIGN.

Signature of Patient or Legal Parent / Guardian

Date

----- PLEASE COMPLETE REVERSE SIDE -----

FAMILY MEDICAL HISTORY

Has a relative (mother/father/sister/brother/grandparent) suffered from any of the following (check one):

DESCRIPTION	YES	NO	RELATIONSHIP
Abn. Bleeding Tendency	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Epilepsy/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
History of stroke at an early age (<50 yr.)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

PERSONAL HEALTH HISTORY

- Do you smoke: Yes No Packs per day: _____ Number of years smoked: _____
- Does a member of your household smoke? Yes No Interested in smoking cessation? Yes No
- Alcohol use: Yes No Frequency: _____ Amount /Type: _____
- Drug Use (social): Yes No Frequency: _____ Amount/Type: _____
- Physical Activity: Yes No Frequency: _____ Amount/Type: _____
- Nutrition: On average, do you eat at least five fruits and vegetables per day? Yes No
- Sexually Active: Yes No Number of partners in the past 12 months? _____
- History of Sexually Transmitted Disease (STD): Yes No Type: _____
- History of sexual contact with person(s) positive for STD: Yes No Type: _____
- Use of Contraception: Yes No Method: _____

Women Only:

- Onset of menstrual cycle: (at age) _____ Duration of cycle (days): _____
- Check one (regarding menstrual cycle):

<i>Cycle:</i>	<input type="checkbox"/> Regular	<input type="checkbox"/> Irregular Flow:	<input type="checkbox"/> Light	<input type="checkbox"/> Medium
<i>Pain:</i>	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Heavy	<input type="checkbox"/> Severe
- Pregnancy History:

Times pregnant	Live births:
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HAVE YOU BEEN TREATED BY A PHYSICIAN FOR ANY OF THE FOLLOWING?

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Dizziness/fainting spells | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Drug abuse | <input type="checkbox"/> Liver disease, hepatitis, yellow jaundice | <input type="checkbox"/> Ulcer in stomach/duodenum |
| <input type="checkbox"/> Allergies to food / pollen | <input type="checkbox"/> Eczema, hives, rashes | <input type="checkbox"/> Lung disease, tuberculosis | <input type="checkbox"/> Unusual childhood illness |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy/seizures/convulsions | <input type="checkbox"/> Menstrual problems | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Eye problems | <input type="checkbox"/> Mumps, measles, chickenpox | <input type="checkbox"/> Vision problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gall bladder disease | <input type="checkbox"/> Nervous breakdown / mental illness | <input type="checkbox"/> Weight-recent gain or loss |
| <input type="checkbox"/> Attention Deficit Disorder/
Hyperactivity Disorder | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Phlebitis / Blood Clots | <input type="checkbox"/> Worry/anxiety |
| <input type="checkbox"/> Cancer, tumor | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Other illnesses: _____ |
| <input type="checkbox"/> Chronic back problems | <input type="checkbox"/> Headaches | <input type="checkbox"/> Rheumatic fever | |
| <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rubella, German measles | |
| <input type="checkbox"/> Chronic skin problems | <input type="checkbox"/> Hernia | <input type="checkbox"/> Sinusitis | |
| <input type="checkbox"/> Colitis/colon problems | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Stomach problems/indigestion | |
| <input type="checkbox"/> Congenital heart disease | <input type="checkbox"/> Infectious mononucleosis | <input type="checkbox"/> Stroke | |
| <input type="checkbox"/> Depression | | <input type="checkbox"/> Suicide attempt | |
| <input type="checkbox"/> Diabetes | | | |
| <input type="checkbox"/> Diminished hearing | | | |

COMMENTS:

1. Have you had any illness, injury, surgery, operation, or been hospitalized other than already noted? (give details) Yes No
2. Have you consulted or been treated by clinics, physicians, or other practitioners within the past five years? (Other than routine checkups) Yes No
3. Has your physical activity been restricted during the past five years? (give reasons and duration) Yes No
4. Have you received treatment or counseling for a nervous condition, personality or character disorder, or emotional problem? (give details) Yes No

If, while at TAMU, you will need any of the following, please indicate below and attach written instructions from your physician:

- Allergy Shots Specialist Care for Chronic Illness Maintenance Medication

Privacy Statement: "State law requires that you be informed of the following: (1) you are entitled to request to be informed about the information about yourself collected by use of this form (with a few exceptions as provided by law); (2) you are entitled to receive and review that information; and (3) you are entitled to have the information corrected at no charge to you."