Medical Health History Form

Student Health Center
University of Missouri Health

This is a **confidential** record of your medical history. Information contained here will not be released to any person except when you have authorized us to do so.

Legal Name: _____ Today's date: _____

Preferred name: _____ Student number: _____

Gender: _____ Date of birth: _____ Birthplace: _____

Countries lived in: _____

Relationship Status: _____ Number of children/step-children: _____ ☐ Military Experience / Veteran

Permanent address _____
Street City State Zip

Permanent phone number: (_____) _____

Person to be notified in case of emergency: _____ Relationship: _____

Address: _____ Phone: (_____) _____
Street City State Zip

Allergies:

Medication: _____

_____

Reaction: _____

Foods: _____

_____

Reaction: _____

Bees/ wasps/ latex/ other: _____

Reaction: _____

Prescribed Medications:
(include contraceptive method)

_____

_____

_____

_____

_____

_____

_____

Habits:

Tobacco use: current #/day_____ ☐former ☐never
Alcoholic beverages (#/week)_____
Recreational drugs:_____
Past use_____
Present use_____
Caffeine drinks/#/day_____
Special diet:_____
Tanning: ☐Y ☐N
Use of seat belts: ☐Always ☐Sometimes ☐Never
Bike helmets ☐Always ☐Sometimes ☐Never ☐N/A
Gambling: ☐Y ☐N
Access to Guns/weapons ☐Y ☐N

Over-the-counter medication: (use/frequency)

Aspirin_____
Acetaminophen (Tylenol)_____
Ibuprofen_____
Vitamins_____
Laxatives_____
Antihistamines_____
Herbals_____
Supplements (exercise, weight loss, etc.) _____
_____
Other_____
_____
_____

Hospitalizations and Surgeries:

Reason Date/Age Place

1. _____
2. _____
3. _____
4. _____

*****Please complete other side*****

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Personal health history: Do you have a *present* or *past* history of: (check all that apply)

- ☐ Acne
- ☐ ADD/ADHD
- ☐ Alcohol abuse
- ☐ Allergies (seasonal)
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Back problems
- ☐ Birth defects
- ☐ Bleeding disorder
- ☐ Blood transfusion
- ☐ Breast condition(s)
- ☐ Broken bone(s)
- ☐ Cancer
- ☐ Chicken pox
- ☐ Chronic diarrhea
- ☐ Constipation
- ☐ Convulsions/seizure
- ☐ Counseling/therapy
- ☐ Depression
- ☐ Diabetes
- ☐ Disability
- ☐ Drug abuse
- ☐ Ear infections
- ☐ Eating disorder/problems
- ☐ Eye disease/problems
- ☐ Fainting spells
- ☐ Foreign travel
- ☐ Gallbladder disease
- ☐ Gastritis/indigestion/reflux
- ☐ GYN problems
- ☐ Head injury
- ☐ Headache _____
- ☐ Hearing loss
- ☐ Heart murmur
- ☐ Heart problems
- ☐ Hepatitis/jaundice
- ☐ Hernia
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ HIV disease
- ☐ Hypoglycemia
- ☐ Inflammatory bowel disease
- ☐ Irritable bowel
- ☐ Joint disease/injury
- ☐ Kidney disease
- ☐ Measles (Rubeola)
- ☐ Meningitis
- ☐ Mononucleosis, Infectious
- ☐ Mumps
- ☐ Paralysis
- ☐ Pneumonia
- ☐ Relationship problems
- ☐ Rheumatic fever
- ☐ Rubella (3-day measles)
- ☐ Sexually Transmitted Infection
- ☐ Sickle Cell anemia/trait
- ☐ Sinus disease
- ☐ Skin problems _____
- ☐ Sleep problems
- ☐ Sprains/dislocations
- ☐ Tattoo/Body piercing
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Ulcer (GI)
- ☐ Urinary Tract Infection
- ☐ Other (list below)

_____
_____
_____
_____
_____

☐ **I have none of the above**

Reproductive Health:

☐ Testicular problem ☐ Prostate problem Do you perform testicular self-exams? ☐ Y ☐ N

☐ Menstrual irregularity ☐ Abnormal Pap smear ☐ Premenstrual syndrome ☐ Menstrual cramps
☐ Hysterectomy ☐ Oophorectomy
☐ Pregnancy #_____ ☐ Miscarriage #_____ ☐ Termination # _____

Do you perform breast self-exams? ☐ Y ☐ N

Family history: Complete the following family history section to the best of your ability. If adopted, check here ☐

	Age	If living, list known medical problems	Age at death	If deceased, list known cause	Has any biologic relative ever had:	Yes	Who
Biological Father					Asthma/Allergies		
					Cancer		
Biological Mother					Diabetes		
					Heart Disease		
Biological Siblings:					High Blood Pressure		
					High Cholesterol		
					Obesity		
					Stroke		
					Tuberculosis		
					Depression/Anxiety		
					Alcohol/Drug Abuse		
					Other		

Will the Student Health Center be your primary health care provider while you are here on campus? ☐ Yes ☐ No

If not, who is your local provider? _____

_____

Student Signature

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