

Medical History

University of Iowa Student Health Service

The University of Iowa Student Health Service requests this confidential information for the purpose of providing patient care. Persons outside the Student Health Service are not routinely provided this information without the patient's knowledge and written consent. Responses to all items are required in order to facilitate appropriate patient care.

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A. Personal Data Male Female Other _____

Name: _____ Student I.D.# _____
(Last) (First) (Middle)

Address: _____ Birthdate: _____
(Number, Street or P.O. Box) (City) (State) (Zip)

Emergency Contact Person: _____
(Last Name) (First) (address) (phone)

Preferred name if different from above: _____

B. Personal/Biological Family Medical History Do you or a member of your immediate family have or had any of the following? (Immediate family: Father, Mother, Brothers, Sisters) **Respond to every item. For items marked "Y" make comments in part D**

Have you ever been hospitalized or had surgery? If so, please specify _____

	You		Family		Relationship		You		Family		Relationship
	Y	N	Y	N			Y	N	Y	N	
Alcohol/Drugs						Hereditary Disease					
Allergies						High Blood Pressure					
Arthritis (disease/injury of joints)						High Cholesterol					
Asthma						Jaundice or Hepatitis					
Cancer						Kidney Disease					
Diabetes						Psychiatric Condition					
Ear, Nose, Throat problems						Seizure disorder					
Eye Disorders (not corrective lenses)						Sexually Transmitted Infection					
Head Injury						Stomach or Intestinal Problems					
Heart Problems/disease						Stroke					
Hemophilia						Other					

Have you ever had treatment for a mental health condition? (Please specify) _____

List any medications you currently take: _____

List any allergies to: Medications (list type of reaction you had) _____
 Food or environmental allergens: _____

C. Social History

1. Do you use tobacco? yes no (If yes, indicate how much and for how long?) _____
2. Do you drink alcohol? yes no (If yes, indicate how much and how often?) _____
3. Do you exercise? yes no (If yes, how often and what form?) _____
4. Do you have any weight or eating concerns? _____
5. Do you need assistance with your normal daily activities? yes no (If yes, please describe) _____
6. Do you have any difficulty understanding English? yes no What is your primary language? _____
7. Do you have any circumstances that affect your ability to understand and learn about health issues? _____
8. If you require an interpreter or other communication assistance, please inform the scheduler when scheduling your appointment.
9. If you have any Advance Directives, such as a living will, please send a copy with this form.

D. Comments: Use this space to make comments from section B, and for any additional information you feel we should know.

E. Verification: _____ Date _____
Student signature

Return this form to: The University of Iowa, Student Health Service, 4189 Westlawn, Iowa City, IA 52242-1100 or Fax to 319-335-7247