

University of Iowa Student Health

MEDICAL HISTORY FORM

Patient name _____

Date of birth _____

Male Female Transgender _____

Preferred name / pronouns of reference

MEDICATIONS

Name of medication / dose / how often taken

ALLERGIES

Name of medication allergy / reaction experienced

PERSONAL HEALTH HISTORY

	Currently	Never	Previously
ADHD / ADD			
Allergies (seasonal, hayfever)			
Anxiety			
Arthritis			
Asthma			
Blood clots/bleeding problem			
Cancer			
Depression			
Diabetes			
Digestive issues			
Heart disease/problem			

	Currently	Never	Previously
High blood pressure			
High cholesterol			
Kidney disease			
Liver disease			
Migraine headaches			
Polycystic Ovarian Syndrome (PCOS)			
Seizure disorder			
Sexually Transmitted Infection			
Stroke			
Thyroid condition			

Other health conditions not listed above

SURGICAL HISTORY

	Yes	No	Date
Adenoids removed			
Appendix removed			
Breast surgery			
Gallbladder removed			
Colonoscopy			
Colposcopy			
Endoscopy			
Eye surgery			

	Yes	No	Date
Laparoscopic surgery			
LEEP			
Oral surgery/wisdom teeth			
Orthopedic surgery			
Spleen removed			
Tonsils removed			
Ear tubes			

Other surgeries not listed above

TURN OVER PLEASE

BIOLOGICAL FAMILY HISTORY

- Adopted
 Family History Unknown

Relationship	Living?	Medical History														
		No Known Problems	Asthma	Blood/Bleeding Problem	Cancer	Depression	Diabetes	Heart Disease	High Cholesterol	High blood pressure	Kidney Disease	Migraines	Seizures	Stroke	Thyroid Disease	Other - please list
Mother	Yes No															
Father	Yes No															
Sibling <input type="checkbox"/> Sister <input type="checkbox"/> Brother	Yes No															
Sibling <input type="checkbox"/> Sister <input type="checkbox"/> Brother	Yes No															
Sibling <input type="checkbox"/> Sister <input type="checkbox"/> Brother	Yes No															
Sibling <input type="checkbox"/> Sister <input type="checkbox"/> Brother	Yes No															
Maternal Grandmother	Yes No															
Maternal Grandfather	Yes No															
Paternal Grandmother	Yes No															
Paternal Grandfather	Yes No															
Other	Yes No															

SOCIAL HISTORY

Sexual History

Are you sexually active?

- Yes
 Not Currently
 No

Gender of sexual partners

- Male
 Female
 Both male & female

Types of sexual activity

- Oral Sex Give Receive
 Vaginal Sex
 Anal Sex Give Receive

Changed partners in the past 3 months?

- Yes
 No

Current method of contraception

- Abstinence Vaginal Ring Implant Natural family planning
 Condom Injection Patch Not needed
 Pill IUD Diaphragm

Do you smoke or use nicotine?

- Yes No

Do you drink alcohol?

- Yes No

Have you used drugs?

- Yes No

Do you feel safe in your living environment?

- Yes No

Undergraduate Student Graduate Student

Major _____

Expected year of graduation _____

Hometown, State, Country _____

GYNECOLOGICAL HISTORY *** Please complete if applicable to today's visit ***

Pap History

- Have you had a Pap Smear? Yes - date? _____ No
 History of abnormal Pap Yes - date? _____ No
 Date of past colposcopy/LEEP _____

Pregnancy History

- Have you ever been pregnant? Yes No
 # of children _____ # of miscarriages _____ # of terminations _____

Menstrual History

- When did your last period start? _____
 Number of days from start of one period to start of the next _____
 Cramping Yes No
 Irregular bleeding Yes No
 Heavy bleeding/clots Yes No
 Bleeding longer than 7 days Yes No

Do you take multivitamins / folic acid daily? Yes No