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?	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																
Father																
Sibling ☐Sister ☐Brother																
Sibling ☐Sister ☐Brother																
Sibling ☐Sister ☐Brother																
Sibling ☐Sister ☐Brother																
Maternal Grandmother																
Maternal Grandfather																
Paternal Grandmother																
Paternal Grandfather																
Other																

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

My Medical History Form is complete and I'm ready to submit by clicking the button to the right ----------