# Medical History-WSU Health & Wellness Services


NAME_____DOB_____

Local (college) Address_____

Local (college) Phone#_____

Major_____Credits_____

Medications/Supplements_____

Allergies_____

Current Medical Conditions_____

## Your Medical History: Circle all that apply

If circled, list year of onset & most recent symptoms

| | | | |
|---|---|---|---|
| Anemia | | Stomach Problems | |
| Asthma | | Thyroid Disease | |
| Bleeding Disorder | | Urinary Tract Infection | |
| Diabetes | | Tuberculosis | |
| Gentic Disorder | | Headache/Migraine | |
| Learning Disabilities | | Heart Problems | |
| Anxiety | | Hepatitis | |
| Depression | | Hernia | |
| Eating Disorder | | High Blood Pressure | |
| Substance Abuse | | Counseling | |
| Mononucleosis | | Major Illnesses/Hospitalizations | |
| Muskuloskeletal Problems | | Major Injuries | |
| Seasonal Allergies | | Major Surgeries | |
| Seizure Disorder | | | |

## Family History

Do your ***parents, grandparents*** (indicate if maternal or paternal grandparent)***, or siblings*** have any of the following:

| | Yes | Which Relative? | | Yes | Which Relative? |
|---|---|---|---|---|---|
| Diabetes | | | Heart Disease | | |
| High Blood Pressure | | | Kidney Disease | | |
| High Cholesterol | | | Cancer | | |
| Heart Attack Before Age 50 | | | Mental Health Illness | | |
| Stroke | | | Substance Abuse | | |

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# Social History/Health Risk Factors

| Do you: | Yes | No | Comment |
|---|---|---|---|
| Drink Alcohol | | | # days per week_____ #days per month_____<br># of drinks at a time_____ |
| Use Tobacco | | | Type_____How Much_____How long_____ |
| Use Recreational/ Street Drugs | | | Type_____Frequency_____ |
| Wear Seatbelts | | | |
| Exercise | | | Type_____Frequency d/w_____<br>Time (minutes)_____ |
| Use Tanning Beds | | | Frequency_____ |
| Feel threatened or afraid of someone in your life? | | | |
| Have a history of assault or abuse? | | | |
| Sleeping Pattern | | | Average Hours Per Night_____ |
| Caffeine Drinks | | | Servings Per Day_____ |
| Calcium-rich foods | | | Servings Per Day_____ |
| Sexually Active | | | Never_____Not in past month_____<br>Condom Use: Always_____ Sometimes_____ Never_____ |
| Have concerns about your weight? | | | |

## Do you have any of these symptoms now? If so, circle.

| | | |
|---|---|---|
| Fever, Chills | Shortness of Breath | Frequent Indigestion |
| Fatigue | Wheezing | Weight gain/loss of >10 Lbs in the past 6 months |
| Abdominal Pain | Rashes | Nausea/Vomitting |
| Changing Moles | Constipation | Change in Vision |
| Diarrhea | Ear Problems | Urinary Problems |
| Sinus Problems | Discharge: Penis/Vagina | Sore Throat |
| Frequent Headaches | Chest Pain | Pain in Muscles or Joints |
| Change in Appetite | Anxiety/Excessive worry | Increased Sadness/Depressed Mood |

Females Only:

First day of last menstrual period_____How often do you get your period?_____

Method of Birth Control:_____ N/A Type:_____

Signature_____

Date_____

This information is strictly for the use of the Health and Wellness services and will not be released to anyone without your knowledge and consent.