

STUDENT HEALTH SERVICES HEALTH HISTORY FORM

THE UNIVERSITY OF KANSAS
1200 SCHWEGLER DRIVE

WATKINS MEMORIAL HEALTH CENTER
LAWRENCE, KS 66045-7559

PHONE (785) 864-9533
FAX (785) 864-5327

1 PATIENT INFORMATION

PATIENT NAME: (PLEASE PRINT)			
LAST: _____	FIRST: _____	MIDDLE: _____	
MAIDEN NAME /OTHER: _____		KU ID #: _____	GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
ETHNICITY/ RACE: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> American Indian <input type="checkbox"/> Asian		DATE OF BIRTH: _____	
<input type="checkbox"/> Alaska Native <input type="checkbox"/> Black or African American <input type="checkbox"/> Unknown		PRIMARY PHONE: _____	
<input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian or Other Pacific Islander		SECONDARY PHONE: _____	

2 PARENT/GUARDIAN INFORMATION

NAME: _____		RELATIONSHIP: _____	
STREET _____		STATE/COUNTRY: _____	
APT/ROOM #: _____	CITY: _____	ZIP: _____	

3 EMERGENCY CONTACT INFORMATION

NAME: _____	RELATIONSHIP: _____	PHONE NUMBER: _____
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4 ALLERGY INFORMATION (Please List; e.g. penicillin, peanuts, etc)

Drug Allergies:
Other Allergies:

5 FAMILY HISTORY (check all that apply)

<input type="checkbox"/> Alcohol/Drug Abuse _____	<input type="checkbox"/> Death before 50 _____	<input type="checkbox"/> Elevated Cholesterol _____	<input type="checkbox"/> Hypertension/Stroke _____
<input type="checkbox"/> Cancer/Type _____	<input type="checkbox"/> Diabetes _____	<input type="checkbox"/> Heart Disease _____	<input type="checkbox"/> Mental Illness _____
<input type="checkbox"/> Other _____			
Brief explanation of any marked history: _____			

6 MEDICAL HISTORY

Do you have a present or past history of: (<input checked="" type="checkbox"/> check all that apply)			
<input type="checkbox"/> ADHD	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Intestinal/Stomach Trouble	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Alcohol Abuse	<input type="checkbox"/> Disability/Handicap	<input type="checkbox"/> Joint Disease/Injury	<input type="checkbox"/> Sexually Transmitted Infections (STI)
<input type="checkbox"/> Allergies (e.g.hayfever)	<input type="checkbox"/> Drug Abuse	<input type="checkbox"/> Measles, Red	<input type="checkbox"/> Sickle Cell Trait/Anemia
<input type="checkbox"/> Anemia	<input type="checkbox"/> Ear Trouble/Hearing Loss	<input type="checkbox"/> Menstrual problems	<input type="checkbox"/> Sinus Trouble
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Migraine Headache	<input type="checkbox"/> Skin Problems; Eczema, Psoriasis
<input type="checkbox"/> Asthma	<input type="checkbox"/> Eye Disease/Problems	<input type="checkbox"/> Mononucleosis, Infectious	<input type="checkbox"/> Sleep Problems
<input type="checkbox"/> Back Problems	<input type="checkbox"/> Gallbladder Trouble	<input type="checkbox"/> Mumps	<input type="checkbox"/> Smoking (how long?) _____
<input type="checkbox"/> Cancer	<input type="checkbox"/> Head Injury	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Spleen, Surgical Removal
<input type="checkbox"/> Chicken Pox (Varicella)	<input type="checkbox"/> Headache (Recurrent)	<input type="checkbox"/> Paralysis	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Colitis	<input type="checkbox"/> Heart Disease/Problems	<input type="checkbox"/> Polio	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Convulsions/Seizures	<input type="checkbox"/> Hepatitis/Jaundice	<input type="checkbox"/> Psychological Counseling	<input type="checkbox"/> Urinary Tract Infection
<input type="checkbox"/> Cough (Chronic)	<input type="checkbox"/> Hernia/Rupture	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Whooping Cough
<input type="checkbox"/> Depression	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Rubella (3-day measles)	<input type="checkbox"/> Other
Brief explanation of any marked medical history			

7 MEDICATION HISTORY (prescription, birth control, over the counter, herbal)

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8 HOSPITALIZATION/SURGERIES (Include Dates)

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9 I verify that the information provided on this form is complete and accurate to the best of my knowledge.

SIGNATURE: _____	PRINT NAME: _____	DATE: _____
Patients Under 18 Years of Age (For All Parents):		
I authorize Student Health Services to administer medical services, procedures, and/or immunizations as deemed necessary.		
PARENT OR GUARDIAN'S SIGNATURE: _____	RELATIONSHIP: _____	DATE: _____