

# UMD Health Services Medical History Form

**Date:** \_\_\_\_\_ **Student ID #** \_\_\_\_\_ **Social Security #:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Name:** \_\_\_\_\_  
 Last First Middle

**Date of Birth** \_\_\_\_ \ \_\_\_\_ \ \_\_\_\_ **Sex:** Female ( ) Male ( ) Transgender ( ) Other ( )

**EMERGENCY CONTACT: (Parent/Guardian/Spouse)**

**Name:** \_\_\_\_\_ **Address:** \_\_\_\_\_  
**Phone:** ( ) \_\_\_\_\_ **City:** \_\_\_\_\_  
**Relationship:** \_\_\_\_\_ **State/Zip** \_\_\_\_\_

**FAMILY HISTORY:** I am adopted. Yes\_\_\_ No\_\_\_, if yes skip to personal health history.

**I have parents, grandparents, brothers and/or sisters with: (please check "X")**

( ) Heart attack/Stroke	( ) Breast Cancer	( ) Alcohol/drug dependency
( ) High blood pressure	( ) Colon Cancer	( ) Mental health problems
( ) Diabetes	( ) Osteoporosis	( ) Other medical conditions _____
( ) Thyroid disease	( ) High Cholesterol	( ) Other cancers _____

**PERSONAL HEALTH HISTORY: I have or had: (please check "X")**

( ) Diabetes	( ) Blood clot disorder	( ) Breast lumps
( ) Rheumatic fever	( ) High cholesterol	( ) Alcohol/drug misuse
( ) Heart disease	( ) Anemia	( ) Thyroid problems
( ) Severe headaches	( ) Asthma	( ) Skin problems/acne
( ) Epilepsy	( ) Liver disease	( ) Mental health problems
( ) High blood pressure	( ) Gallbladder disease	( ) Suicide attempt/Suicide thoughts
( ) Changes in weight	( ) Urinary tract infection	( ) Anxiety/Depression
( ) Eating disorder	( ) Varicose veins	( ) Sleep Difficulties

**Hospitalizations/operations list:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Female Health:** Regular Menstrual Cycle? ( ) YES ( ) NO  
 Age of 1<sup>st</sup> Menstrual Cycle: \_\_\_\_\_

**Male Health:** Self Testicular Exam? ( ) YES ( ) NO

**REGULAR MEDICATIONS:** (including Birth Control, Vitamins, Supplements, Herbals, Over the Counter)


<b>ALLERGIES to the following:</b>	<b>IMMUNIZATIONS:</b>
<b>Medications: (please list below)</b>	Have you completed the Hepatitis B Series? ( ) YES ( ) NO
	Have you had the Meningitis Vaccine? ( ) YES ( ) NO
<b>Food: (please list)</b>	Date of last known Diphtheria/Tetanus Injection:
<b>Latex:</b> ( ) YES ( ) NO	

Do you smoke/chew tobacco? ( ) NO ( ) YES Amount: \_\_\_\_\_

Do you drink alcohol? ( ) NO ( ) YES how many drinks per day? \_\_\_\_\_

Do you use any other substances? ( ) NO ( ) YES Specify type: \_\_\_\_\_ Amount: \_\_\_\_\_

Describe your regular exercise routine: \_\_\_\_\_

How many meals in a day do you eat? \_\_\_\_\_

Are you a vegetarian? ( ) Yes ( ) No Are you happy with your current weight? ( ) Yes ( ) No

How much sleep do you receive in an average day? \_\_\_\_\_ hours per day.

What are your stress management techniques: \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date: \_\_\_\_\_ medhistory3 10/06