The University of Texas at Dallas Student Health Services
VOICE: (972) 883-2747/FAX: (972) 883-2069

HEALTH HISTORY QUESTIONNAIRE

PERSONAL INFORMATION

Legal Name: _____ Sex: M F Intersex Gender: Man Woman Other:_____
Last First M.I.

Preferred Name: _____ Age:_____ Date of Birth:_____

Student I.D.#: _____ Marital/Relationship Status: _____ Race (opt.): _____

Current Address: _____ Phone #: (___) _____
Street/P.O. Box City, State, Zip

Cell #: (___) _____

Permanent Address: _____ Phone #: (___) _____
Street/P.O. Box City, State, Zip

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship to you: _____

Phone Number: (_____) _____

MEDICINES YOU ARE TAKING

(List medicines, birth control pills, vitamins, herbal/dietary supplements and over the counter meds you take with or without a prescription)

_____

_____

DRUG AND/OR OTHER ALLERGIES

(List those you are allergic to and reactions)

_____

_____

HEALTH CARE PROVIDERS

Name of Family Health Care Provider: _____ Phone #: (_____) _____

When was your last complete physical? _____ Please list below anyone else you may have received healthcare from in the past:

Year	Name of Doctor or Other Provider	Location City, State	Primary Problems Cared for

FAMILY HEALTH HISTORY

Has a relative (mother/father/sister/brother/grandparent) suffered from any of the following (check one):

DESCRIPTION	YES	NO	RELATIONSHIP
Abn. Bleeding Tendency	[ ]	[ ]	_____
Cancer	[ ]	[ ]	_____
Diabetes	[ ]	[ ]	_____
Epilepsy/Seizures	[ ]	[ ]	_____
Heart Disease	[ ]	[ ]	_____
High Blood Pressure	[ ]	[ ]	_____
History of stroke at an early age (<50 yr.)	[ ]	[ ]	_____
Tuberculosis	[ ]	[ ]	_____
Other: _____	[ ]	[ ]	_____

In accordance with Leg. House Bill 1922, an individual is entitled to: request to be informed about the information collected about them; receive and review their information; and correct any incorrect information.

More on back side of form (please turn over)

PERSONAL HEALTH HISTORY

- Do you smoke: [ ] Yes [ ] No Packs per day: _____ Number of years smoked: _____
- Does a member of your household smoke? [ ] Yes [ ] No Interested in smoking cessation? [ ] Yes [ ] No
- Alcohol use: [ ] Yes [ ] No Frequency: _____ Amount/Type: _____
- Drug Use (social): [ ] Yes [ ] No Frequency: _____ Amount/Type: _____
- Do you exercise? [ ] Yes [ ] No Frequency: _____ Amount/Type: _____
- On average, do you eat a healthy diet? [ ] Yes [ ] No Vegetarian [ ] Non-Vegetarian [ ]
- Have you ever been a victim of domestic abuse or intimate partner violence? [ ] Yes [ ] No
- Have you ever been sexually active: [ ] Yes [ ] No Number of partners in the past 12 months: _____
- Have you ever had oral sex? [ ] Yes [ ] No Have you ever had anal sex? [ ] Yes [ ] No
- Sexual Orientation: [ ] Heterosexual [ ] Lesbian/Gay [ ] Bi-sexual [ ] Asexual
- History of Sexually Transmitted Disease (STD): [ ] Yes [ ] No Type: _____
- History of sexual contact with person(s) positive for STD: [ ] Yes [ ] No Type: _____
- Method of Contraception: Abstinence / Birth control pills / DEPO / Patch / Other _____
- Use of condoms to prevent STD/STI's: [ ] Yes [ ] No
- Age at first period: _____ How often do your periods occur? _____

Check One (regarding menstrual cycle)

Cycle: [ ] Regular [ ] Irregular *Flow*: [ ] Light [ ] Medium
Pain: [ ] None [ ] Mild [ ] Heavy [ ] Severe

PREGNANCY HISTORY (females only

Enter the number of:

Times pregnant _____

Live births _____

Abortions/Miscarriages _____

HAVE YOU BEEN TREATED BY A PHYSICIAN FOR ANY OF THE FOLLOWING?

[ ] Abnormal Bleeding
[ ] Alcoholism
[ ] Anemia
[ ] Anxiety
[ ] Arthritis
[ ] Asthma
[ ] Cancer, tumor
[ ] Chronic back problems
[ ] Chronic cough
[ ] Chronic skin problems
[ ] Congenital heart disease
[ ] Colitis/colon problems
[ ] Depression
[ ] Diabetes
[ ] Diminished hearing
[ ] Dizziness/fainting spells
[ ] Drug abuse
[ ] Eczema, hives, rashes
[ ] Epilepsy/seizures/convulsions
[ ] Eye problems
[ ] Food allergies
[ ] Gall bladder disease
[ ] Glaucoma
[ ] Hay fever/pollen allergies
[ ] Heart disease
[ ] Headaches
[ ] Hepatitis
[ ] Hernia
[ ] High blood pressure
[ ] Infectious mononucleosis
[ ] Kidney disease
[ ] Liver disease, hepatitis, yellow jaundice
[ ] Lung disease, tuberculosis
[ ] Menstrual problems
[ ] Mumps, measles, chickenpox
[ ] Mental health concerns/mental illness
[ ] Phlebitis
[ ] Pneumonia
[ ] Rheumatic fever
[ ] Rubella, German measles
[ ] Sinusitis
[ ] Stomach problems/indigestion
[ ] Stroke
[ ] Suicide attempt
[ ] Thyroid disease
[ ] Ulcer in stomach/duodenum
[ ] Unusual childhood illness
[ ] Vision problems
[ ] Weight-recent gain or loss
[ ] Other illnesses

_____
_____
_____

COMMENTS:

- Has your physical activity been restricted during the past five years? (give reasons and duration) [ ] Yes [ ] No
- Have you had difficulty with school, or studies? (give details) [ ] Yes [ ] No
- Have you ever received mental health counseling? (give detail) [ ] Yes [ ] No
- Have you had any illness or injury or been hospitalized other than already noted? (give details) [ ] Yes [ ] No
- Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past five years? (Other than routine checkups) [ ] Yes [ ] No

If, while at UTD, you will need any of the following, please indicate below and attach written instructions from your physician:

[ ] Specialist Care for Chronic Illness
[ ] Maintenance Medication

Authorization for Treatment: I hereby certify that the above history is complete to the best of my knowledge and I do hereby give permission for the UTD Student Health Service provider(s): doctors, nurse practitioners and nurses to perform whatever diagnostic treatment, examinations, and procedures necessary to maintain my good health for as long as I am a student at The University of Texas at Dallas.

I authorize UTD Student Health Services to release any medical and/or billing information to my insurance company, necessary to process claims, relating to the care provided by this office.

If you are under age 18 years of age, your legal guardian must sign.

_____ _____

Signature of Student or Legal Guardian Date