COLUMBUS STATE UNIVERSITY STUDENT HEALTH CENTER

NAME:_____ ID #: 909_____ Age:_____ Date:_____

MEDICATION ALLERGIES:_____

ALLERGIES (Food/Environmental/Seasonal):_____

LIST OF CURRENT MEDICATIONS (Prescription, Non Prescription, Birth Control, Inhaler, Supplement):_____

_____

(CHECK ALL THAT APPLY)

PERSONAL MEDICAL HISTORY

- ☐ ADD/ADHD
- ☐ Alcohol or Drug Dependency
- ☐ Anemia or Blood Disorder
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Bipolar Disorder
- ☐ Bone Fracture _____ Year_____
- ☐ Cancer
- ☐ Diabetes
- ☐ Depression
- ☐ Eating Disorder
- ☐ Eczema
- ☐ Epilepsy or Seizures
- ☐ Gastrointestinal Problems
- ☐ Hearing Loss/Problem
- ☐ Heart Attack/Disease or Stroke
- ☐ High Blood Pressure
- ☐ Kidney Disease / Stone
- ☐ Liver Disease or Jaundice
- ☐ Migraine Headaches
- ☐ Ovarian Cyst
- ☐ Pap History Date _____
- ☐ Polycystic Ovarian Syndrome
- ☐ Pregnancy Number _____ Number of live births_____
- ☐ STD History _____
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Other _____
- ☐ None _____

(CHECK ALL THAT APPLY)

YOUR SOCIAL HISTORY

- ☐ Alcohol Use: ☐ Yes ☐ No
- ☐ Abuse (Physical, sexual, emotional or verbal)
  - ☐ Current ☐ History of
- ☐ Employment: ☐ Full-time ☐ Part-time
- ☐ Exercises Regularly
- ☐ Exercises Intermittently
- ☐ Gun Ownership
- ☐ Marital Status: ☐ Single; ☐ Married; ☐ Separated; ☐ Divorced; ☐ Widowed
- ☐ Sexual Activity:
  - ☐ Has never been sexually active
  - ☐ Not currently sexually active
  - ☐ Currently sexually active with one partner
  - ☐ Currently sexually active with multiple partners
- ☐ Seatbelt Use: ☐ Always; ☐ Never; ☐ Rarely
- ☐ Tobacco Use: ☐ None; ☐ Cigarettes; ☐ Cigars; ☐ Chewing; ☐ Dipping; ☐ Previous Use

  Number of Years _____ Per day _____
- ☐ Vape Number of Years _____
- ☐ Weed/Marijuana Number of years _____
- ☐ Drug Use ☐ Yes ☐ No

NAME:_____ **ID #: 909**_____

(CHECK ALL THAT APPLY)

Specify Family Member. Example: Mother/Father, Grandmother/Grandfather, Brother/Sister.

FAMILY HISTORY

- ☐ Adopted - Unknown Family History
- ☐ I am a twin
- ☐ Alcohol or Drug Dependency_____
- ☐ Anemia or Blood Disorder_____
- ☐ Anxiety_____
- ☐ Arthritis_____
- ☐ Asthma_____
- ☐ Bipolar Disorder_____
- ☐ Cancer_____
- ☐ Diabetes_____
- ☐ Depression_____
- ☐ Epilepsy or Seizures_____
- ☐ Gastrointestinal Problems_____
- ☐ Heart Attack or Stroke_____
- ☐ High Blood Pressure_____
- ☐ High Cholesterol_____
- ☐ Kidney Disease_____
- ☐ Liver Disease or Jaundice_____
- ☐ Migraine Headaches_____
- ☐ Thyroid Problems_____
- ☐ Tuberculosis_____
- ☐ Other_____
- ☐ Unknown
- ☐ NONE

(CHECK ALL THAT APPLY)

YOUR SURGICAL HISTORY

- ☐ Abortion
- ☐ Adenoidectomy
- ☐ Appendectomy
- ☐ Biopsy Results _____ Date _____
- ☐ Cholecystectomy (gallbladder)
- ☐ Circumcision
- ☐ C-Section Date _____
- ☐ D & C
- ☐ Fracture Repair
- ☐ Hernia Repair
- ☐ Knee Arthroscopy
- ☐ LASIX
- ☐ Myringotomy (tubes in ears)
- ☐ Ovarian Cyst Removal
- ☐ Shoulder Rotator Cuff Repair
- ☐ Tonsillectomy
- ☐ Tonsillectomy & Adenoidectomy (T&A)
- ☐ Wisdom Teeth Extraction
- ☐ Other Surgery_____
- ☐ NONE

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