

American University Student Health Center Personal Health History Form

Name: _____
Last
First
Middle

AUID# _____ Anticipated Graduation Date _____

Local Address: _____

Phone #: _____ Date of Birth: _____

Permanent Address: _____

In Case of Emergency notify: _____ Relationship to you: _____

Address: _____ Telephone: _____

Telephone: _____

ALLERGIES TO MEDICATIONS: _____

ALLERGIES – OTHER: _____

Current medications: _____

Do you smoke? Yes No Never Smoked If yes, how much _____ (quit date _____)

Do you drink? Yes No (Number of drinks per week _____)

Have you ever had:	Yes	No	Explain "Yes" Responses and Give Dates
Attention Deficit/Hyperactivity Dis.			
Alcohol/Drug Problems			
Anemia			
Anorexia/Bulimia/Eating Problems			
Asthma			
Cancer			
Chronic Bronchitis			
Cholesterol or lipid problems			
Chronic Skin Disease (eg eczema, psoriasis)			
Convulsions, Seizures (epilepsy)			
Diabetes			
Digestive Track Disease (eg ulcer, colitis)			
Fractures/Bones Broken			
Gallbladder/Liver Disease			
Glaucoma			
Hay Fever			
Headaches (migraine)			
Heart Disease			
Hepatitis/Yellow Jaundice			
High Blood Pressure			
HIV Infection			
Kidney or Bladder Disease			
Mononucleosis or Infectious Mono			
Orthopedic problem			
Pneumonia			
Prolonged Depression or Anxiety			
Radiation Treatment			
Sexually Transmitted Diseases (please list)			
Speech, Hearing, or vision problem			
Removal of spleen			
Stroke			
Thyroid or Hormone Disturbance			
Transfusion or blood/blood product			
Tuberculosis			

Have you ever been hospitalized? Yes No

Dates: _____ Reason: _____

Have you ever had surgery? Yes No

Dates: _____ Reason: _____

FOR WOMEN: Last Pap Smear Date: _____ Result _____

Last Mammogram Date: _____ Result _____

Family History

If any member of your immediate family (parents, grandparents, siblings, or children) has any of the following, please circle and indicate which family member.

Alcoholism _____ High Blood Pressure _____ Mental Illness/suicide _____
Cancer _____ Stroke _____ Hepatitis/Jaundice _____
Diabetes _____ Kidney Disease _____ Tuberculosis _____
Heart Disease _____ High Cholesterol _____

	Age, if Living	Any Significant Illnesses	If Deceased, Age & Cause of Death
Father			
Mother			
Siblings			
Spouse			
Children			

Student's Signature _____

Date _____

The purpose of this questionnaire is to provide information to aid Health Center practitioners with your continued medical care, both in emergency and routine situations.