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.