University of Wisconsin
Eau Claire
Student Health Service

Name: _____
Blugold ID: _____
Date of Birth: _____
Today's Date: _____

Health History Form

All students must complete this from
(ALL INFORMATION IS CONFIDENTIAL)

Personal Medical History

Please check all conditions you currently have or have had in the past. If you have no past or current personal medical problems please check the starred box.

Preferred Name (nickname, etc.)_____
_____

Gender

- ☐ Female
- ☐ Male
- ☐ Other (specify) _____
- ☐ Transgender (preferred pronoun) _____

Medical History

- ☐ **NO HISTORY OF SIGNIFICANT HEALTH PROBLEMS**
- ☐ Anemia
- ☐ Asthma
- ☐ Cancer
- ☐ Celiac Disease
- ☐ Cholesterol or Lipid Abnormalities
- ☐ Diabetes
- ☐ Gastrointestinal Problem (colitis, Crohn's, etc.)
- ☐ Heart Murmur
- ☐ Heart/Cardiovascular Disease
- ☐ Hypertension (high blood pressure)
- ☐ Joint/Rheumatologic Disorder
- ☐ Kidney Disease
- ☐ Liver Disease/Hepatitis
- ☐ Reflux Disease/Ulcers
- ☐ Reproductive/Sexual Health Problem
- ☐ Significant Injury/Trauma (when) _____
- ☐ Thyroid Disease
- ☐ Acne
- ☐ Autoimmune Disorder
- ☐ Bleeding Disorder
- ☐ Blood Clot
- ☐ Blood Transfusion (when) _____
- ☐ Concussion
- ☐ Environmental Allergy (pollen, animals, etc.) (Specify)_____
- ☐ Genetic Disorder
- ☐ Headaches (frequent)
- ☐ Headaches (Migraines)
- ☐ Hearing Impairment
- ☐ HIV/AIDS
- ☐ Learning Disability
- ☐ Neurologic Problem(s)
- ☐ Physical Disability
- ☐ Seizure Disorder/Epilepsy
- ☐ Sickle Cell Disease/Trait
- ☐ Tuberculosis
- ☐ Visual Impairment (excluding glasses/contact use)

Mental Health

- ☐ ADD/ADHD
- ☐ Alcohol Dependency/Abuse
- ☐ Anxiety Disorder
- ☐ Anxiety with Panic Attacks
- ☐ Bipolar Disorder
- ☐ Depression
- ☐ Eating Disorder
- ☐ Insomnia/ Sleep Problem(s)
- ☐ Other Mental Health _____
- ☐ Substance Abuse
- ☐ Suicide Attempt

Social History

Alcohol Use ☐ current ☐ past
Drug/Substance Use ☐ current ☐ past
Tobacco Use ☐ current ☐ past

Other History

- ☐ NEVER IMMUNIZED- did NOT receive vaccinations
- ☐ OTHER HISTORY- Please list _____

_____
_____
_____

CONTINUE →

Family Medical History

Please check any condition present in your family (identify immediate family members ONLY- parents, siblings, grandparents)

List individual(s) on line to the right of condition

☐** NO HISTORY OF FAMILY HEALTH PROBLEMS**

☐** UNKNOWN FAMILY MEDICAL HISTORY**

☐Cancer _____

☐Cholesterol or Lipid Abnormalities_____

☐Diabetes_____

☐Glaucoma_____

☐Heart Attack_____Age_____

☐Heart/Cardiovascular Disease_____

☐Hypertension (high blood pressure) _____

☐Osteoporosis_____

☐Stroke _____Age_____

☐Thyroid Disease_____

☐Autoimmune Disorder_____

☐Bleeding Disorder_____

☐Blood Clot_____

Mental Health

☐Alcohol Dependency/Abuse_____

☐Anxiety Disorder_____

☐Bipolar Disorder_____

☐Depression_____

☐Eating Disorder_____

☐Other Mental Health _____

☐Suicide/Suicide Attempt_____

Other

☐Sudden, Unexpected Death <60 years of age (no trauma) _____Age_____

☐Other History-Please List_____

_____

_____

_____

Surgeries and Hospitalizations

Please list all surgeries and hospitalizations (including overnight stays) you have had in the past.

☐None

Procedure Date of

_____

_____

_____

_____

Allergies

Include medications and any other allergy of significance, such as latex, foods, and dyes.

☐None

Name Reaction

_____

_____

_____

_____

_____

***THANK YOU** for completing your Health History Form!*