



CONFIDENTIAL
HEALTH HISTORY QUESTIONNAIRE

Please answer every question below as best you can. This will help us to give you the best possible medical care. If the space provided to answer questions is not adequate, attach sheet with additional information. Note: PLEASE PRINT.

Name: _____ Date of Entry to IU _____
(last or family) (first) (middle/maiden)

University Identification (UID) #: _____ College or School _____ Sex: F ___ M ___

Date of Birth: _____ Home Phone #: _____

Home Address: _____
(street) (city) (state) (zip)

Bloomington Address, if known: _____ Local Phone #: _____

Marital Status _____ Height _____ Weight _____
(single, married, divorced, widowed)

IN CASE OF EMERGENCY, PERSON TO NOTIFY:

Name: _____ Relationship _____ Home Phone #: _____
Business Phone #: _____

Home Address _____
("same" if same as above) (city) (state) (zip)

INSURANCE: Do you have health insurance? Yes ___ No ___ Company Name: _____

HOME PHYSICIAN, HEALTH CLINIC OR FACILITY:

Name: _____ Phone #: _____

Address: _____
(street) (city) (state) (zip)

IMMUNIZATIONS: MMR: Date of Dose 1 _____ Date of Dose 2 _____
Tetanus: Date of most recent _____

Have you had an initial series of 3 polio vaccines: yes ___ no ___ Most recent booster: _____

Have you ever had a TB skin test: yes ___ no ___ If yes, result: _____ Date of most recent: _____

Meningitis vaccine: Date _____

Have you completed the hepatitis B vaccine series? ___ Have you had: chickenpox vaccine? ___ chickenpox disease? ___

Please check in the appropriate column indicating health problems you have had.

Anemia	Anxiety	Bladder Infections	Bleeding Disorder	Blood Clot in Lung	Cancer/Tumor/Leukemia	Chest Pain	Chicken Pox	Deafness/Hearing Loss	Depression	Digestive Problems	Ear Problems	Eating Disorder	Eye Problems	Fainting Spells	German Measles	Headaches	Head Injury	Heart Attack	Heart Disease	Hepatitis/Problem	Hepatitis/Jaundice	High Blood Pressure	Hyperventilation	Insomnia	Kidney Disease/Stones	Malaria	Measles	Mononucleosis	Mumps	Neck/Back Problems	Obesity	Phlebitis

Pregnancy	Prostatitis	Rheumatic Fever	Sickle Cell Anemia	Skin Problems	Speech Disability	Stroke	Suicide Attempt/Act or Disease	Tuberculosis Exposure	Ulcer

Other Medical Problems Not Listed Above: _____

Give a brief statement of your general health. _____

If you check yes to any question below, describe problems in detail.

	YES	NO	Details of Medical History
1. Do you have any current medical problems?	___	___	
2. Are you taking any prescription or over-the-counter medications, nutritional or dietary supplements, herbs... on a regular basis? (List all substances, dosages, and reasons for taking.)	___	___	
3. Are you allergic to any medications? If yes, what? What is your reaction?	___	___	
4. Does your health prevent you from participating in any physical activities?	___	___	
5. Have you had any chronic illnesses, serious illnesses or physical disabilities?	___	___	
6. Have you had any surgeries or been hospitalized for any reason? (Describe and give approximate dates.)	___	___	
7. Do you have asthma? (If so, has the condition been stable for a year?)	___	___	
8. Are you allergic to dust, molds, pollens, insect stings, foods? If yes, explain severity and means of treatment.	___	___	
9. Do you smoke or use tobacco products? ___ # packs per day ___ # of years	___	___	
10. Do you drink alcohol? If yes, how many drinks do you have in an average week? _____	___	___	
11. Do you have or have you had seizures? (Describe type of seizure, severity, and frequency.) List medications and dosages taken for seizures. Give date of last seizure.	___	___	
12. Do you have diabetes, thyroid trouble or other endocrine problems?	___	___	
13. Have you ever been under the care of a psychologist, psychiatrist, or counselor? If yes, when _____ for what reason _____	___	___	

FAMILY HISTORY: For your family members below, follow the line across the page and mark an X in those boxes which indicate their present state of health (good), (poor), or their death (write in the cause), and any of the illnesses that they have ever had. Print the names of your relatives living or dead in the spaces below.

	Health				Cause of Death	Alcohol/Drug Addiction	Allergy	Anemia	Arthritis	Cancer	Depression/Suicide Attempt	Diabetes	Gout	Heart Attack/Disease	High Blood Pressure	Kidney Stone	Mental Illness	Migraine Headaches	Sickle Cell Trait	Stroke	Tuberculosis
	Good	Poor	Deceased	Age at Death																	
Father:																					
Mother:																					
Brothers or Sisters:																					
Spouse:																					
Children:																					
Grandparents: (Mark an X for illnesses only)																					

Student's Signature: _____ Date: _____

If you will be under 18 years of age during your enrollment at Indiana University, please have your parent/guardian sign the following.

Consent for Treatment

I grant permission to Indiana University Health Center to evaluate and treat medical and psychological problems of my above named child.

Parent/Guardian Signature: _____ Date: _____