THE UNIVERSITY OF IOWA

Student Health Service Medical History

[Label]

The University of Iowa Student Health Service requests this confidential information for the purpose of providing patient care. Persons outside the Student Health Service are not routinely provided this information without the patient's knowledge and written consent. Responses to all items are required in order to facilitate appropriate patient care.

A. Personal Data ☐ Male ☐ Female ☐ Transgender _____

Name: _____ **Student I.D.#**_____
(Last) (First) (Middle)

Address: _____ **Birthdate:** _____
(Number, Street or P.O. Box) (City) (State) (Zip)

Emergency Contact Person: _____
(Last Name) (First) (address) (phone)

Preferred name if different from above: _____

B. Personal/Biological Family Medical History Do you or a member of your immediate family have or had any of the following? (Immediate family: Father, Mother, Brothers, Sisters) **Respond to every item. For items marked "Y" make comments in part D**

	You		Family				You		Family		
	Y	N	Y	N	Relationship		Y	N	Y	N	Relationship
Alcohol/Drugs						Hereditary Disease					
Allergies						High Blood Pressure					
Arthritis (disease/injury of joints)						High Cholesterol					
Asthma						Jaundice or Hepatitis					
Cancer						Kidney Disease					
Diabetes						Psychiatric Condition					
Ear, Nose, Throat problems						Seizure disorder					
Eye Disorders (not corrective lenses)						Sexually Transmitted Infection					
Head Injury						Stomach or Intestinal Problems					
Heart Problems/disease						Stroke					
Hemophilia						Other					

Have you ever been hospitalized or had surgery? If so, please specify_____

Have you ever had treatment for a mental health condition? (Please specify) _____

List any medications you currently take: _____

_____

List any allergies to: Medications (list type of reaction you had) _____

Food or environmental allergens: _____

C. Social History

1. Do you use tobacco? ☐ yes ☐ no (If yes, indicate how much and for how long?)_____
2. Do you drink alcohol? ☐ yes ☐ no (If yes, indicate how much and how often?)_____
3. Do you exercise? ☐ yes ☐ no (If yes, how often and what form?) _____
4. Do you have any weight or eating concerns? _____
5. Do you need assistance with your normal daily activities? ☐ yes ☐ no (If yes, please describe)_____
6. Do you have any difficulty understanding English? ☐ yes ☐ no What is your primary language?_____
7. Do you have any circumstances that affect your ability to understand and learn about health issues? _____
8. If you require an interpreter or other communication assistance, please inform the scheduler when scheduling your appointment.
9. If you have any Advance Directives, such as a living will, please send a copy with this form.

D. Comments: Use this space to make comments from section B, and for any additional information you feel we should know.

_____

_____

_____

E. Verification: _____ _____
Student signature Date

Please scan and email this form to: student-health@uiowa.edu **OR Fax to 1-319-335-7247 one month before your arrival.**