Medical History

University of Iowa Student Health Service

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.

You Family	ė-	A. Personal Data		Male		Female \square	Other			_		
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Ear, Nose, Throat problems Eye Disorders (not corrective lenses) Head Injury Heart Problems/disease Hemophilia 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.			+ +	+	+-	+		+-	 	\vdash	┼┼┤	
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