

The University of Iowa Student Health Service requests this information for the purpose of providing patient care. No persons outside the University of Iowa Student Health Service are routinely provided this information without your consent.

Name _____ Student I.D#: _____
Last first middle initial nickname

Age _____ Sex _____ Marital Status _____ No. of Children _____ Hometown _____ Date of Birth _____

Local Address _____

Phone Number _____ Is it okay to leave a message at this number? _____

Education:

High School (city, state) _____ Year Graduated _____ Rank/G.P.A. _____

Previous College: _____ Dates attended _____ Major: _____

U of I Major _____ Current G.P.A. _____

Past Medical History:

Serious accidents, illnesses, operations? _____

Any current health problems? _____

Are you now using any prescribed medication(s)? (include OTC drugs, birth control pills, herbal supplements)
If yes, please list: _____

Any allergies to medications? _____ If yes, please list: _____

Any previous psychiatric treatment or counseling? _____ Describe: _____

Family History:

Father: Age _____ Occupation _____ If _____

Mother: Age _____ Occupation _____

[Pt Label]

Brothers: Number _____ Ages _____

Sisters: Number _____ Ages _____

Family Religion _____

Family Illness - mental and/or physical: Grandparents, parents, brothers, sisters, aunts, uncles, cousins: