FSU
UNIVERSITY
HEALTH SERVICES
DIVISION OF STUDENT AFFAIRS

HEALTH HISTORY FORM

For Office Use Only

Patient # _____

Patient Name: John Doe DOB: 3 / 1 / 1998

PERSONAL MEDICAL HISTORY:

(Yes) No	Do you have any allergies (include medications, latex, insect stings or food type)? If yes, please list and reaction type : Peanuts
(Yes) No	Do you take regular medications (include birth control, vitamins, supplements, etc)? If yes, please list: Birth Control
(Yes) No	Overnight Hospitalizations (non ER). Indicate reason and dates: Stabbed in face 9/11/2001
Yes (No)	Past Surgeries. Indicate type of surgery and date:

PERSONAL MEDICAL HISTORY

Do you have or have you ever had any of the following?

If yes, please check ☑ and explain below.

Yes		Yes	
X	Alcohol / Drug dependency		Hypoglycemia
X	Seasonal Allergies		Kidney Problems
	Anemia / Blood disease		Liver Problems
	ADD/ADHD		Malaria
X	Anxiety / Depression		Mononucleosis
	Arthritis		Musculoskeletal Problems
	Asthma		Neurological Problems
X	Back Problems		Pregnancy , history of
	Blood Clots (legs, lungs)	X	Psychological Disorders
	Blood Transfusions	X	Sexually Transmitted Infection
	Bronchitis / Pneumonia		Strep Throat
	Cancer		Skin Condition
	Concussion / Head Injury		Thyroid Problems
	Diabetes		Tuberculosis / Positive PPD
	Ear Problems		TMJ (jaw problems)
	Eating Disorders		Urinary Tract Infections
	Epilepsy/Seizures		
	Eye / Vision Problems		
	Fractures / History of Injury		
	Gastrointestinal Problems		
	Headaches		
	Heart Problem / Murmur		Other:
	High Blood Pressure		
	High Cholesterol		

FAMILY MEDICAL HISTORY

Does anyone in your immediate family have any of the following conditions? (IE MOTHER, FATHER, SISTER, BROTHER & GRANDPARENTS)

Yes		Indicate which Family Member
X	Alcohol / Drug / Substance Dependency	Dad
	Anemia/Blood / Clotting Problem	
X	Anxiety/ Depression	Mom
	Arthritis	
	Asthma / Allergies	
	Cancer Specify:	
	Diabetes	
	Eating Disorders	
	Epilepsy, Seizures	
	Gastrointestinal Problems	
	Heart Attack / Stroke	
	High Blood Pressure	
	High Cholesterol	
	Kidney Disease	
	Liver Disease	
	Neurological Problems	
	Psychological Disorders	
	Thyroid Problems	
	Tuberculosis	
	Other:	

IF *YES,* please explain: _____

_____

_____

Patient Signature: _____ **Date:** _____

7/11, Rev 10/11, 4/13, 10/14, 5/18,9/22