Date entered:

Last updated:

Validated by:

Western
UNIVERSITY · CANADA

Student Health Services

Intake History

Demographic Information

Student Number:

First Name:

Last Name:

Date of Birth:

Sex:

Emergency Contact

Name:

Telephone:

Address:

Home Physician

Name:

Telephone:

Address:

Academic Information

Faculty:

Enrollment Status:

Academic Year:

Allergies

Are you allergic to any drugs?

Please list the names of ALL drugs to which you are allergic and provide details on reactions or symptoms for each:

Drug 1:	Reaction(s)/Symptoms(s):
Drug 2:	Reaction(s)/Symptoms(s):
Drug 3:	Reaction(s)/Symptoms(s):
Drug 4:	Reaction(s)/Symptoms(s):
Drug 5:	Reaction(s)/Symptoms(s):
Drug 6:	Reaction(s)/Symptoms(s):
Drug 7:	Reaction(s)/Symptoms(s):
Drug 8:	Reaction(s)/Symptoms(s):

Are you presently receiving allergy shots?

Do you have any NON-DRUG allergies?

Please indicate (check) if you are allergic to any of the following:

Bee or wasp sting	Ragweed pollen
Other pollen(s)	Grasses
Dust allergy	Animal Fur
Any other agent(s)	Food(s)

Prescriptions

Do you take ANY prescription drugs (INCLUDING BIRTH CONTROL PILLS or ACNE MEDICATION) at this time:

Please indicate the names of any medications you are currently taking:

Drug 1:

Drug 2:

Drug 3:

Drug 4:

Drug 5:

Drug 6:

Drug 7:

Medical History

Have you had any serious past illness(es) that have required hospitalization OTHER THAN OPERATIONS?

Please list all serious past illness(es) you have had and indicate your age at the time of each illness:

Illness 1: Age:

Illness 2: Age:

Illness 3: Age:

Illness 4: Age:

Illness 5: Age:

Illness 6: Age:

Have you had any operations?

Please list all operations you have had and indicate your age at the time of each operation:

Operation 1: Age:

Operation 2: Age:

Operation 3: Age:

Operation 4: Age:

Operation 5: Age:

Operation 6: Age:

Medical Conditions

Please indicate if you have, or have had the following conditions and provide details if Yes:

Broken bones:	Describe:
Migraine:	Describe:
Neurological disorder:	Describe:
Asthma:	Describe:
Pneumonia:	Describe:
Lung disease:	Describe:
Heart disease:	Describe:
Ulcer:	Describe:
Bowel Disease:	Describe:
Hepatitis:	Describe:
Positive HIV test:	Describe:
Thyroid problem:	Describe:
Blood disorder:	Describe:
Diabetes:	Describe:
Blood transfusion:	Describe:
Cancer or leukemia:	Describe:
Sexual Disease:	Describe:

Please indicate if you have, or have had the following conditions and provide details if Yes:

Urinary infection:	Describe:
Emotional disorder:	Describe:
Arthritis:	Describe:
Eating Disorder:	Describe:
Osteoporosis:	Describe:
Skin Problems:	Describe:
High Blood Pressure:	Describe:
Learning disability:	Describe:
Schizophrenia:	Describe:
Alcohol Dependency:	Describe:
Multiple Sclerosis:	Describe:
Stroke:	Describe:
High cholesterol:	Describe:
Depression:	Describe:
Drug dependency:	Describe:
Other disease:	Describe:

Immunizations

Please indicate yes or no if you have been immunized and the year of your last booster (if known) for each of the following:

Hepatitis B (Serum Hepatitis):	Year:
Tetanus (Lockjaw):	Year:
Polio:	Year:
MMR (Mumps, Measles, Rubella):	Year:
Year of last TB skin test:	Year:
Rubella:	Year:
Varicella (Chickenpox):	Year:
Meningitis:	Year:
Pneumococcus:	Year:

Please indicate if you have HAD the disease and the year by selecting yes or no, and the year from the drop down boxes:

Hepatitis B (Serum Hepatitis):	Year:
Tetanus (Lockjaw):	Year:
Polio:	Year:
MMR (Mumps, Measles, Rubella):	Year:
Year of last TB skin test:	Year:
Rubella:	Year:
Varicella (Chickenpox):	Year:
Meningitis:	Year:
Pneumococcus:	Year:

Do you have your immunization history card with you?

Social History

How often do you wear a seatbelt?

Are you a smoker at present?

How much do you smoke (individual cigarettes per day)?

Did you smoke in the past?

Do you use street drugs of any kind?

Do you drink alcohol?

On average, how many drinks do you have per occasion?

On average, how many drinks do you have per week?

On average, how many hours do you exercise per week?

Family History

Please indicate if and which members of your biological family (siblings, mother, father, aunts, uncles, and grandparents) have the following conditions:

Migraine:	Describe:
Neurological Disorder:	Describe:
Asthma:	Describe:
Pneumonia:	Describe:
Lung Disease:	Describe:
Heart Disease:	Describe:
Ulcer:	Describe:
Bowel Disease:	Describe:
Hepatitis:	Describe:
Thyroid Problem:	Describe:
Blood Disorder:	Describe:
Diabetes:	Describe:
Blood Transfusion:	Describe:
Cancer or Leukemia:	Describe:
Urinary infection:	Describe:
Emotional Disorder:	Describe:
Arthritis:	Describe:
Osteoporosis:	Describe:
Skin Problems:	Describe:
High Blood Pressure:	Describe:
Learning Disability:	Describe:
Schizophrenia:	Describe:
Alcohol Dependency:	Describe:
Multiple Sclerosis:	Describe:
Stroke:	Describe:
Cholesterol:	Describe:
Depression:	Describe:
Drug Dependency:	Describe:

Current Issues

For each of the following body systems please indicate any problems you may be having in your own words:

General:

Nervous System:

Head, Eyes, Ears, Nose, Throat:

Neck:

Chest:

Heart:

Gastrointestinal:

Genitals and Urinary systems:

Psychiatric:

Womens' Health

If you are a female patient, please complete the following questions:

How old were you when you had your first period?

Do you get your period every month?

How long does your period last (days)?

Do you experience severe cramps with your periods?

Do you experience unusual or mid-cycle bleeding?

Have you ever had pelvic inflammatory disease?

Have you ever had an ovarian cyst (cyst on an ovary)?

Have you ever had breast cancer?

Have you ever had a breast lump or breast mass?

Have you ever been pregnant?

Have you ever had a therapeutic abortion?

At what age did you have an abortion?

Have you EVER had a Pap test?

Have you ever had an abnormal Pap test result?

What was the year of your last Pap test?

Have you ever used a birth control pill (oral contraceptive)?

Please indicate the birth control pills you have used:

Birth Control 1.

Birth Control 2.

Birth Control 3.

Birth Control 4.

What birth control pill are you using now?

Are you having problems with your present birth control pill?

Do you practice monthly breast self-examination (BSE)?

Sexual Health

Please indicate your sexual history:

Have you ever had sexual intercourse?

Have you ever had sex with a male?

Have you ever had sex with a female?

At what age did you first have sexual intercourse?

How many partners did you have intercourse with in the last year?

How often do you use condoms?

Please indicate if you have had the following sexually transmitted diseases:

Have you ever had a sexually transmitted disease (STD)?

Venereal warts/HPV:

Chlamydia:

Gonorrhea:

Genital Herpes:

Syphilis: