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• Memorial Union •
• LL045 • 600 Park Street • Hays, KS 67601-4099
• 785.628.4293 • 785.628.4089 FAX
• www.fhsu.edu/studenthealth •

STUDENT HEALTH CENTER

HEALTH HISTORY QUESTIONNAIRE

FILL OUT THIS FORM COMPLETELY. PRINT LEGIBLY.
Completion of this form is required **before** receiving non-urgent care at the Student Health Center.

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *Last* *First* *M.I.*	☐ Male ☐ Female ☐ Transgender	**FHSU ID #**
Marital Status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		**DOB:**

CURRENT MEDICATIONS (INCLUDE DOSE & FREQUENCY): include prescriptions, birth control, over the counter, herbal

_____

_____

_____

ALLERGIES or REACTIONS TO MEDICINES, FOODS: (example: penicillin, peanuts, bee stings, latex)	
Medications:	Food:
Insect Stings:	Other:

SEXUAL HISTORY

Your answers to the following questions will help us to assess your risk for cervical cancer and sexually transmitted infections (STIs)

YES NO

☐ ☐ Are you sexually active now? Check all that apply: Vaginal /Anal/ other. When did you last have sex _____?
☐ ☐ Have you had more than one or new sexual partner in the last year? Are your partners Male/ Female/ Both
☐ ☐ Do you take precautions against sexually transmitted infections? Explain:

SOCIAL/HEALTH RISK HISTORY

YES NO

☐ ☐ Do you smoke or use tobacco? Amount per day _____
☐ ☐ Do you use alcohol? If yes, how often/how much _____?
☐ ☐ Do you or your partners use street or IV (injectable) drugs/ share needles of any kind?
☐ ☐ Have you ever had or would you like help now with an alcohol or drug abuse problem?
☐ ☐ Are you now or have you ever been in a relationship where you have been physically or emotionally hurt or threatened?
☐ ☐ Do you exercise?
☐ ☐ Do you feel safe at home?
☐ ☐ Do you have concerns about your weight, diet, eating disorder?
☐ ☐ Do you know where you could go or who could help if you were abused or worried about abuse?
☐ ☐ Do have concerns about your stress level or sleep patterns?

Name:_____ DOB:_____

HEALTH HISTORY QUESTIONNAIRE, continued

FAMILY HISTORY

☐ If you are adopted, check and skip to the next section.

Has anyone in your immediate family ever had the following? If yes, indicated father (F), mother (M), brother (B), or sister (S).

_____ No longer living (Age/Cause of death:_____)

_____ Heart Attack/Heart Disease/Surgery (Age at onset_____)

_____ High Blood Cholesterol/ High Blood Pressure

_____ Genetic Defect

_____ Breast, Ovarian, or Uterine Cancer (Age at onset _____)

_____ Other Cancer

_____ Diabetes (Insulin dependent? ☐ Yes ☐ No)

PAST MEDICAL HISTORY

YES NO

☐ ☐ Have you ever had surgery or been a patient in a hospital?
If yes, describe: _____

☐ ☐ Are you now, or have you been, under a doctor's care for a serious illness or condition?
If yes, describe: _____

FEMALE PATIENTS ONLY

CONTRACEPTIVE HISTORY

Check all birth control methods you have used:

☐ Pill ☐ IUD ☐ Condoms ☐ Sterilization ☐ Depo ☐ Diaphragm ☐ Patch ☐ Vaginal Ring ☐ Natural Family Planning (Rhythm)
☐ Withdraw ☐ Foam/Suppository/Sponge ☐ Other

YES NO

☐ ☐ Do you or your partner use birth control now?
☐ ☐ If yes, what methods do you use?_____ How long have you used this method? _____
☐ ☐ Have you had problems with this birth control method? If yes, explain: _____
☐ ☐ Do you plan to get pregnant in the next year?
☐ ☐ Do you want a birth control method today? If yes, what method? _____

MENSTRAL HISTORY

Last normal period_____

Age periods started?_____

How often do you get your period?_____

YES NO

☐ ☐ Was your last menstrual period normal?
☐ ☐ Have you had intercourse since your last period?
☐ ☐ Are you concerned that you could be pregnant now?
☐ ☐ Severe cramps?
☐ ☐ Missed periods?
☐ ☐ Bleeding between periods?

PREGNACY HISTORY

☐ Never Pregnant (skip to next section)

Do you think that you are pregnant now? Yes ☐ No ☐

Age at first pregnancy _____

Total pregnancies _____

# of living children _____

Abortions _____ Dates _____

Miscarriages _____ Dates _____

Are you breastfeeding now? Yes ☐ No ☐

Name:_____ DOB:_____

REVIEW OF SYSTEMS

1. General

YES	NO	
☐	☐	My Health is generally good
☐	☐	Recent weight gain or loss (>25 lbs.)
☐	☐	Frequent colds, flu, ect.
☐	☐	Chronic fatigue (> 6 months)
☐	☐	Cancer_____
☐	☐	Genetic Condition

2. Immunizations

YES	NO	
☐	☐	Hepatitis B
☐	☐	Vaccine/shot for Rubella/MMR
☐	☐	Tetanus Vaccine shot
☐	☐	Meningitis
☐	☐	Gardisil

3. Cardiovascular

YES	NO	
☐	☐	Heart Disease/Murmur
☐	☐	High Blood Cholesterol/Triglycerides
☐	☐	High Blood Pressure
☐	☐	Thrombophlebitis/Blood Clots in veins or lungs
☐	☐	Sub-Acute Bacterial Endocarditis

4. Neurological

YES	NO	
☐	☐	Stroke
☐	☐	Migraine (Diagnosis by MD)
☐	☐	Sensory difficulties (numbness, hearing, taste, smell)
☐	☐	Seizures/Epilepsy

5. Gastrointestinal

YES	NO	
☐	☐	Stomach/bowel problems
☐	☐	Liver disease/jaundice
☐	☐	Hepatitis
☐	☐	Gall Bladder disease

6. Endocrine

YES	NO	
☐	☐	Diabetes/Diabetes of pregnancy
☐	☐	Thyroid problems

7. Respiratory

YES	NO	
☐	☐	Asthma
☐	☐	Chronic Cough
☐	☐	Other breathing problems

8. Genitourinary

YES	NO	
☐	☐	Frequent bladder infections (>3 per year)
☐	☐	Bladder, urinary or kidney problems
☐	☐	Abnormal pap smear
☐	☐	Abnormality of uterus
☐	☐	Pelvic Infection/Pain/PID
☐	☐	Recurrent vaginal infections
☐	☐	Sexually transmitted disease: Chlamydia/Gonorrhea/Herpes Syphilis/Genital Warts/Other
☐	☐	Breast Problems: Discharge/ Disease/Tumor/Surgery

9. Hematologic

YES	NO	
☐	☐	Anemia
☐	☐	Blood clotting disorder
☐	☐	Blood transfusion
☐	☐	Sickle Cell Anemia/Trait/ Thalassemia/PKU

10. Skin

YES	NO	
☐	☐	Acne
☐	☐	Chronic rash/itching
☐	☐	Other skin problems

11. Musculoskeletal

YES	NO	
☐	☐	Arthritis
☐	☐	Broken bones/fractures

12. Eyes

YES	NO	
☐	☐	Eye problems (other than glasses)

13. Ears / Nose / Throat / Mouth

YES	NO	
☐	☐	Hearing Problems
☐	☐	Frequent nosebleeds
☐	☐	Frequent sore throat
☐	☐	Teeth/Gum Problems

14. Psychology

YES	NO	
☐	☐	Depression
☐	☐	Anxiety
☐	☐	Severe mood swings
☐	☐	Under care of psychiatrist / psychologist

Over 18: I, hereby give the Student Health Center permission to request supporting documentation for required immunizations and treat me as they deem necessary when I present myself to the Student Health Center.

_____ _____

Student's Signature Date

Under 18: I, the parent/guardian of _____, hereby authorize and give permission to the Student
(Print Patient's Full Name)
Health Center request supporting documentation for required immunizations and treat my child whenever my child presents themselves to Student Health Center.

_____ _____

Parent/Guardian Date

Clinician Signature _____ Date_____

Annual Review #1

☐ No Change ☐ Change (see physical exam notes)

Clinician Signature _____ Date_____

Annual Review #2

☐ No Change ☐ Change (see physical exam notes)

Clinician Signature _____ Date_____