

University of Wisconsin Oshkosh Student Health Center    **HEALTH HISTORY**  
□ NEW PATIENT    □ PHYSICAL

NAME:		<input type="checkbox"/> Man <input type="checkbox"/> Woman <input type="checkbox"/> Transgender		ID#:
PREFERRED NAME:		Email Address:		
Local Address (include city, state & zip):		Birth date:		
Local Phone: Cell Phone:		<b>Current Prescribed Medications (list all including birth control):</b>		
<b>ALLERGIES (List All and Type of reaction)</b>		<b>Medication</b>	<b>Dosage (if known)</b>	
<b>HOSPITALIZATIONS/SURGERY (List All)</b>		<b>Current Herbal/Vitamins or Non-Prescribed Medications</b>		
<b>Year</b>	<b>Reason:</b>	<b>Medication</b>	<b>Dosage (if known)</b>	
<b>Who do you want notified in case of an emergency?</b>				
Name:		Relationship:		
Home Phone:		Work Phone:		Cell Phone:
<b>Health Habits:</b>				
1. Do you smoke cigarettes? <input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, how many/day? _____ # years: _____ Use smokeless tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you want to quit? <input type="checkbox"/> Yes <input type="checkbox"/> No    # of Quit Attempts: _____				
2. Do you use street drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, what type? _____ How often? _____				
3. Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, how many drinks per week? _____ Have you felt you needed to cut down? <input type="checkbox"/> Yes <input type="checkbox"/> No				
4. Do you exercise regularly? <input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, what type? _____ How often? _____				
5. Do you use seat belts regularly? <input type="checkbox"/> Yes <input type="checkbox"/> No				
6. How long have you been sexually active?    Anal    Oral    Vaginal <b>If N/A, skip to #10.</b>				
7. Number of lifetime partners:		Number of months with current partner:		Last sexual encounter:
Have your sexual partners been:		Male	Female	both
8. Have you ever had a STD? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, <b>circle all that apply:</b> Chlamydia    Gonorrhea    HPV/Genital Warts    Genital Herpes    HIV    Other: _____				
9. Are you presently using a method of birth control: (circle) Pill    Ring    Depo    Plan B    Condom    None    Other: _____				
10. Are you aware that emergency contraception (morning after pill) is available for women? <input type="checkbox"/> Yes <input type="checkbox"/> No				
11. Do you have any questions or concerns regarding any of the following?				
a. Family alcoholism or drug abuse? <input type="checkbox"/> Yes <input type="checkbox"/> No				
b. Your appearance, weight or nutrition? <input type="checkbox"/> Yes <input type="checkbox"/> No				
c. Rape, sexual abuse or unwanted sexual activity? <input type="checkbox"/> Yes <input type="checkbox"/> No				
d. Dating/Domestic violence or stalking? <input type="checkbox"/> Yes <input type="checkbox"/> No				
e. Termination of pregnancy (you or partner)? <input type="checkbox"/> Yes <input type="checkbox"/> No				
12. During the past month, have you felt sad, lonely, down, depressed or hopeless? <input type="checkbox"/> Frequently <input type="checkbox"/> Rarely <input type="checkbox"/> Never				
13. During the past month, have you felt little interest or pleasure in doing things? <input type="checkbox"/> Frequently <input type="checkbox"/> Rarely <input type="checkbox"/> Never				
<b>FAMILY HEALTH HISTORY</b>	<b>Mom</b>	<b>Dad</b>	<b>Sibling</b>	
Alcoholism				High blood pressure
Drug abuse				High cholesterol
Blood or clotting disorder				Cancer/type:
Depression/psychiatric illness				
Diabetes				Hereditary disease
Stroke				Tuberculosis
Heart disease				Sudden unexpected Death before age 50
Thyroid Problems				Other serious illness

**(OVER)**

**PERSONAL HISTORY: Have you had or do you now have:**

	Past	Present	No		Past	Present	No		Past	Present	No
<b>Head/Neurologic</b>				<b>Heart/Circulation/Chest</b>				<b>Genitourinary</b>			
Headaches- occasional				Severe chest pain/pressure				Urinary/kidney Problem			
Migraine:				Heart disease or murmur				Frequent Bladder Infection			
Circle: Rare Occasional Frequent				Rapid or irregular pulse				<b>Chronic Diseases</b>			
				Blood clots/vein problems				Diabetes			
				<b>Respiratory</b>				Asthma			
Dizziness or fainting				Chronic cough > 1 month				High blood pressure			
Loss of consciousness				Pneumonia				Arthritis			
Head injuries				Tuberculosis or + PPD				Sickle cell disease			
<b>Eyes</b>				Shortness of breath				Seizures or Epilepsy			
Vision or eye problems				<b>Gastrointestinal</b>				Thyroid Disease			
Glasses/contact lenses				Abdominal pain (severe/recurrent)				Elevated Cholesterol			
<b>Last eye exam (year):</b>				Heartburn				Obesity			
<b>Ears/Nose/Throat</b>				Ulcer				<b>Psychiatric</b>			
Allergies or hay fever				Hepatitis				Anxiety			
Ear or hearing problems				Stomach/Bowel movement problems				Depression			
Frequent sinusitis				Gallbladder disease				Bipolar			
Dental problems				<b>Last dental exam (year):</b>				Other mental health concerns			
<b>Skin</b>				Hernia				<b>Additional Medical History</b>			
Severe acne or skin disorder				<b>Musculoskeletal</b>				ADD/Learning disability			
New or changing moles				Swollen or painful joints or extremities				Cancer			
<b>Blood Disorder</b>				Chronic or severe back problems				Unusual Fatigue > 1 month			
Anemia								Recent gain or loss of weight > 10 pounds			
Bleeding disorder								Eating Disorder			
Enlargement of glands or lymph nodes								<b>Other</b>			

**Explain all "Yes" answers from above:**

**WOMEN'S HEALTH (women answer only)**

1. Do you have monthly periods? <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Last period:</b>	(mo/day/yr)
2. Date of your last pap smear? Month/Year	Was it normal? <input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Do you have a history of abnormal paps? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, when? _____	
4. Have you had any special procedures because of an abnormal pap? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, when?	
5. Have you received the HPV Vaccine ( 3 injections) <input type="checkbox"/> Yes 1 2 3 <input type="checkbox"/> No		
6. Have you had education about breast self- examination (BSE)? <input type="checkbox"/> Yes <input type="checkbox"/> No		
7. Have you ever been pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, when?	Complications?
a. How many: live births?	Miscarriages?	Terminations?
8. Have you ever had or do you now have:		
a. Breast lumps or discharge	<input type="checkbox"/> Past <input type="checkbox"/> Present <input type="checkbox"/> No	
b. Vaginal infections or abnormal discharge	<input type="checkbox"/> Past <input type="checkbox"/> Present <input type="checkbox"/> No	
c. Pain or bleeding with intercourse or outercourse	<input type="checkbox"/> Past <input type="checkbox"/> Present <input type="checkbox"/> No	
d. Ovarian cysts or endometriosis	<input type="checkbox"/> Past <input type="checkbox"/> Present <input type="checkbox"/> No	

**MEN'S HEALTH (men answer only)**

1. Do you have any penile discharge or change in urination?	<input type="checkbox"/> Past <input type="checkbox"/> Present <input type="checkbox"/> No
2. Have you ever had undescended testicles, testicular problems or cancer?	<input type="checkbox"/> Past <input type="checkbox"/> Present <input type="checkbox"/> No
3. Have you ever had prostate problems?	<input type="checkbox"/> Past <input type="checkbox"/> Present <input type="checkbox"/> No
4. Do you regularly examine your testicles for swelling or lumps?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**TRANSGENDER HEALTH**

1. Hormone Therapy	<input type="checkbox"/> Past <input type="checkbox"/> Present <input type="checkbox"/> No
2. Male to Female Surgery	<input type="checkbox"/> Past <input type="checkbox"/> Present <input type="checkbox"/> No
3. Female to Male Surgery	<input type="checkbox"/> Past <input type="checkbox"/> Present <input type="checkbox"/> No

**STUDENT'S SIGNATURE:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Provider comments:** \_\_\_\_\_

**Reviewed by:** \_\_\_\_\_ **Date:** \_\_\_\_\_