KU WATKINS HEALTH SERVICES
The University of Kansas

HEALTH HISTORY FORM

Watkins Health Center
1200 Schwegler Drive • Lawrence, KS 66045
785-864-9500 • FAX: 785-864-9502
www.studenthealth.ku.edu

Name: ______________________ **KU ID#:** __________ **Date of Birth:** __________

MEDICATION HISTORY ☐ *No Current Medications*

Include all prescription, birth control, over-the-counter, vitamins, supplements, and herbal preparations that you take.

Name of Medication, including dosage and frequency (i.e., 250 mg, one tab, twice daily)

____

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FOOD / MEDICATION / MATERIAL ALLERGIES (Include all substances: penicillin, latex, peanuts, etc.)

☐ **No Known Food/Medication/Material Allergies**

Name of Food/Medication/Material	Type of Reaction	Approx. Date of Onset

PERSONAL MEDICAL HISTORY ☐ *No Significant Personal Medical History*. Please select all that apply:

- _____ Acid Reflux/GERD
- _____ Anemia
- _____ Anxiety Disorder
- _____ Asthma
- _____ Attention Deficit (ADD/ADHD)
- _____ Bipolar Disorder
- _____ Cancer/Type:__________
- _____ Concussion
- _____ Clotting Disorder
- _____ Depression
- _____ Diabetes
- _____ Eating Disorder
- _____ Hay Fever/Allergies
- _____ Hearing Impairment
- _____ Heart Disease
- _____ Heart Murmur
- _____ Hepatitis B or C
- _____ High Blood Pressure
- _____ High Cholesterol
- _____ HIV Infection
- _____ Liver Disease
- _____ Mononucleosis
- _____ Migraine Headaches
- _____ Palpitations
- _____ Other:______________________________
- _____ Sexually Transmitted Infection
- _____ Sickle Cell Trait
- _____ Substance/Alcohol Use
  - ❍ Alcohol Drinks/week:_________
  - ❍ Smoking: ( ) Former ( ) Current
  - ❍ Tobacco Use/Other: _________
  - ❍ Recreational Drug Use
- _____ Suicidal Thoughts/Attempt(s)
- _____ Thalassemia
- _____ Thyroid Disorder
- _____ Urinary/Kidney Problems

Parents & Siblings Medical History

❑ No Significant Family History

- _____Alcohol/Substance Abuse
- _____Cancer: __________
- _____Clotting Disorder
- _____Depression
- _____Diabetes
- _____Heart Disease
- _____High Blood Pressure
- _____High Cholesterol
- _____Thyroid Disorder
- _____Other:__________

What do you use for STI (sexually transmitted infection) protection? ______________________

HOSPITALIZATION / SURGICAL HISTORY *(include dates)* ☐ No Past Hospitalizations/Operations

Condition(s): ____

____

TO BE COMPLETED BY FEMALE PATIENTS ONLY: GYNECOLOGY HISTORY

1. ☐Yes ☐ No Do you skip periods?
2. ☐Yes ☐ No Have you had irregular bleeding?
3. ☐Yes ☐ No Recurrent vaginal infections
4. Contraception: *Check method used in the past and currently*
   - ☐past ☐ now Oral contraceptives — If used, what type of pill? ______________________
   - ☐past ☐ now Depo Provera ☐past ☐ now Condoms ☐past ☐ now Spermicide
   - ☐past ☐ now Birth Control Implant (Nexplanon) ☐past ☐ now IUD — Brand: __________
   - Other (specify)______________________________
   - How long was each method used?______________________________
   - Were there any problems? ______________________________
5. Date of last pelvic exam: ______________________
6. Date of last Pap smear? ______________________ Was it normal? ☐Yes ☐ No
7. Date of last menstrual period? ______________________
8. Number of pregnancies? ______________ Number of live births ______________
9. ☐Yes ☐ No Have you had GYN surgery? If yes, give date and describe: ______________________

Patient Signature: ______________________________ Date: ______________

*************************** *DO NOT WRITE BELOW THIS LINE - FOR INTERNAL USE ONLY* ***************************

Document Review Date: ______________ Provider's Initials:______________