Student Health Center
University of Missouri Health

Medical Health History Form

This is a **confidential** record. Information will not be released to any person except when you have authorized us to do so.

Legal Name: ____________________ **Today's Date**: ____________

Preferred Name: ____________ **Pronouns:**____________ **Student Number**:____________

Sex Assigned at Birth: ____________ **DOB**:____________ **Birthplace**:____________

Sexual Orientation ☐ Lesbian, gay or homosexual ☐ Straight or heterosexual ☐ Bisexual ☐ Don't know ☐ Choose not to disclose ☐ Other____________

Gender Identity. ☐ Identify as male ☐ Identify as female ☐ Female to Male (FTM)/Transgender Male/Trans Man ☐ Male to Female (MTF)/Transgender Female/Trans Woman ☐ Genderqueer, neither exclusively male or female ☐ Choose not to disclose ☐ Other ____________

Relationship Status:____________ **Number of children/step-children**:______ ☐ **Military Experience/Veteran**

Countries Lived In:____________

Person to notify in case of emergency:____________ **Relationship**:____________

Address:____________ **Phone**:____________
Street City State Zip

Allergies:

Medications:____________

____

Reaction: ____________

Foods: ____________

Reaction: ____________

Bees/ wasps/ latex/ other: ____________

Reaction: ____________

Prescribed Medications: (include contraceptive method)

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Habits:

Tobacco use: current #/day______ ☐ former ☐ never
Alcoholic beverages (#/week):____________
Recreational drugs: ☐ current ☐ former ☐ never
Past use:____________
Present use:____________
Caffeine drinks (#/day):____________
Special diet:____________
Tanning: ☐ Yes ☐ No
Use of seat belts: ☐ Always ☐ Sometimes ☐ Never
Bike helmets: ☐ Always ☐ Sometimes ☐ Never ☐ N/A
Access to guns/weapons: ☐ Yes ☐ No

Over-the-Counter Medication: (use/frequency)

Aspirin____________
Acetaminophen (Tylenol)____________
Ibuprofen (Advil)____________
Vitamins____________
Laxatives____________
Antihistamines____________
Herbals____________
Supplements (exercise, weight loss, etc.)
____
Other____________

Hospitalizations and Surgeries:

Reason Date/Age Place

1. ____________

2. ____________

3. ____________

*****Please complete other side*****

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Personal Health History: Do you have a *present* or *past* history of: (check all that apply)

- ☐ Acne
- ☐ ADD/ADHD
- ☐ Alcohol abuse
- ☐ Allergies (seasonal)
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Back problems
- ☐ Birth defects
- ☐ Bleeding disorder
- ☐ Blood transfusion
- ☐ Breast condition(s)
- ☐ Broken bone(s)
- ☐ Cancer
- ☐ Chicken pox
- ☐ Chronic diarrhea
- ☐ Constipation
- ☐ Convulsions/seizure
- ☐ Counseling/therapy
- ☐ Depression
- ☐ Diabetes
- ☐ Disability
- ☐ Drug abuse
- ☐ Ear infections
- ☐ Eating disorder/problems
- ☐ Eye disease/problems
- ☐ Fainting spells
- ☐ Foreign travel
- ☐ Gallbladder disease
- ☐ Gastritis/indigestion/reflux
- ☐ GYN problems
- ☐ Head injury
- ☐ Headache ______________
- ☐ Hearing loss
- ☐ Heart murmur
- ☐ Heart problems
- ☐ Hepatitis/jaundice
- ☐ Hernia
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ HIV disease
- ☐ Hypoglycemia
- ☐ Inflammatory bowel disease
- ☐ Irritable bowel
- ☐ Joint disease/injury
- ☐ Kidney disease
- ☐ Measles (Rubeola)
- ☐ Meningitis
- ☐ Mononucleosis, Infectious
- ☐ Mumps
- ☐ Paralysis
- ☐ Pneumonia
- ☐ Relationship problems
- ☐ Rheumatic fever
- ☐ Rubella (3-day measles)
- ☐ Sexually Transmitted Infection
- ☐ Sickle Cell anemia/trait
- ☐ Sinus disease
- ☐ Skin problems __________
- ☐ Sleep problems
- ☐ Sprains/dislocations
- ☐ Tattoo/Body piercing
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Ulcer (GI)
- ☐ Urinary Tract Infection
- ☐ Other (list below)

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____
____

☐ **I have none of the above**

Reproductive Health:

☐ Testicular problem ☐ Prostate problem Do you perform testicular self-exams? ☐ Yes ☐ No

☐ Menstrual irregularity ☐ Abnormal Pap smear ☐ Premenstrual syndrome ☐ Menstrual cramps

☐ Hysterectomy ☐ Oophorectomy

Pregnancy #______ Delivery #______ Miscarriage #______ Termination # ______

Do you perform breast self-exams? ☐ Yes ☐ No

Family History: Complete the following family history section to the best of your ability. ☐ **Adopted/Family History Unknown**

	Age	If living, list known medical problems	If deceased, Age at death	Cause of death
Biological Father				
Biological Mother				
Biological Brother/Sister				
Biological Brother/Sister				
Biological Brother/Sister				
Biological Brother/Sister				
Biological Brother/Sister				

Will the Student Health Center be your primary health care provider while you are here on campus? ☐ Yes ☐ No

If not, who is your local provider? ____

____

Student Signature