Medical Health History Form

Student Health Center
University of Missouri

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

Legal Name _____ **DOB** _____

Preferred Name _____ **Pronouns** _____ **State/Country of Origin** _____

Sex Assigned at Birth _____

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 □ Male to Female (MTF)/Transgender Female/Trans Woman
□ Female to Male (FTM)/Transgender Male/Trans Man □ Genderqueer, neither exclusively male or female □ Choose not to disclose
□ Other _____

Allergies
Medications _____
Reaction _____
Foods _____
Reaction _____
Bees/ wasps/ latex/ other _____
Reaction _____

Prescribed Medications (include contraceptive method)

Habits:
Tobacco/Nicotine use □ never □ former □ current #/day _____
If current or former user □ cigarettes □smokeless □vape
If former, how long ago did you quit? _____
Alcohol use □ never □ former □ current
If current, #drinks/week _____ average drinks per setting _____
Recreational drug use □ never □ former □ current
Past use of what drug _____
Present use of what drug _____
Caffeine drinks (#/day) _____
Type of diet _____
Exercise times/week _____ duration (min) _____
Type _____

Over-the-Counter Medication (use/frequency)
Aspirin _____
Acetaminophen (Tylenol) _____
Ibuprofen (Advil) _____
Vitamins _____
Laxatives _____
Allergy Medications _____
Herbals _____
Supplements (exercise, weight loss, etc.)
_____
Other _____
_____

Overnight Hospitalizations, Surgeries and Trauma

Reason for Hospitalization	Date	Surgery (type)	Date	Trauma	Date
□None		□None		□None	

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

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Reproductive Health

Have you been sexually active in the past year? □ Yes □ No

Do you regularly use condoms? □ Yes □ No □ Not applicable

Number of sexual partners in the past year? ___ Partners are □ Male □ Female □ Both □ _____

Have you had STI testing in the past year? □ Yes □ No □ Not applicable

Personal Medical/Family History Complete the following to the best of your ability. □ **Adopted** □ **Family History Unknown**

Father-□ Living □ Deceased Mother-□ Living □ Deceased Siblings-Total #_____ (# Living _____ # Deceased _____)

Please indicate with a check mark (✓) if you or a family member (parents, siblings)

Medical Condition	You	Family	Specify family member & condition
NONE	□	□	
Acne (requiring prescription medication)	□	□	
ADD/ADHD	□	□	
Alcoholism/Alcohol Abuse	□	□	
Anemia	□	□	
Anxiety	□	□	
Asthma	□	□	
Blood Disease/Clotting Disorder	□	□	
Cancer	□	□	
Concussion/Head Injury	□	□	
Depression	□	□	
Diabetes	□	□	
Drug Abuse	□	□	
Eating Disorder/Problems	□	□	
Heart Attack/Heart Disease/Heart Surgery	□	□	
Hepatitis	□	□	
High Blood Pressure	□	□	
HIV	□	□	
Migraine Headaches	□	□	
Seizure Disorder	□	□	
Sexually Transmitted Infections	□	□	
Stomach / Intestinal Problems	□	□	
Stroke	□	□	
Thyroid Disease	□	□	
Tuberculosis	□	□	
List other medical problems currently under treatment (Be Specific)	□	□	

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 **Today's Date**

Reviewed by Provider_____ Date_____