UL LAFAYETTE - STUDENT HEALTH SERVICE
PATIENT HISTORY FORM

NAME: _____ TODAY'S DATE: _____

SOCIAL SECURITY #: _____ DATE OF BIRTH:_____

SOCIAL HISTORY:

Marital Status: _____ # of children: _____

Daily Patterns:
dietary (meals/day): _____
sleeping habits: # hours of sleep/night: _____
do you nap: ☐ yes ☐ no
exercise (times/week): _____

Educational Major: _____
Occupation: _____
Religion: _____
Disabilities: _____
Ethnicity/Race: _____

Habits:
Tobacco: _____ # of cig a day; ____# of years
Alcohol: _____ # of drinks day; ___ week
Caffeine _____ # cups/drinks per day

Medication(s) presently taking:
Prescription: _____
Non-prescription: _____
Street Drug: _____

FAMILY HISTORY:

Family Members	*Alive*	*Deceased*	*Age at Death*	*Cause of Death*
Mother				
Father				
# of Sisters ____				
# of Brothers ____				

Check the diseases that are present in your ***immediate family*** (i.e., parents, grandparents and/or siblings).

☐ Breast Cancer _____ ☐ Diabetes Mellitus _____ ☐ Pulmonary Embolism/DVT _____
☐ Cancer, Other _____ ☐ Thyroid disease _____ ☐ Other:
☐ Stroke _____ ☐ Allergies _____ _____
☐ Seizures _____ ☐ Kidney Disease _____ _____
☐ Heart Disease _____ ☐ Mental Disease _____ _____
☐ High Blood Pressure _____ ☐ Sickle Cell Anemia _____ _____
☐ Lung disease _____ ☐ High Cholesterol _____ _____

PAST MEDICAL HISTORY:

List your ***drug allergies*** and your ***sensitivities*** to drugs, food, latex, tape, etc:

_____
_____

Check the ***childhood diseases*** that you have had and the year in which they occurred:
☐ Measles: _____ ☐ Mumps: _____ ☐ Chicken pox: _____ ☐ Other: _____

Check and then record the most recent date of each of the ***immunizations*** listed:
☐Tetanus: _____ ☐ MMR: _____ ☐ Meningococcal: _____ ☐ Hepatitis A: _____ ☐ Hepatitis B: _____

Check the ***surgical*** procedures that you have had and the year in which they occurred:
☐ Tonsillectomy: _____ ☐ Tubes in ears: _____ ☐ Dental surgery: _____
☐ Appendectomy: _____ ☐ Other: _____

List all of your ***hospitalization*** dates(s) and reason(s) for admission:

_____
_____

List all the ***accidents(s)/injury(s)*** that you have had and the date(s) of occurrence:

_____
_____

CHECK ANY PROBLEMS/ DISEASE(S) THAT YOU HAVE HAD IN THE PAST:

☐ headache (migraine, other)
☐ visual abnormality (glasses, other)
☐ glaucoma/cataract/blindness
☐ seasonal allergies
☐ chronic sinusitis
☐ asthma
☐ skin abcess
☐ cancer: type _____
☐ seizure
☐ stroke
☐ hypoglycemia
☐ diabetes: type_____
☐ high blood pressure
☐ high cholesterol
☐ anemia: type_____
☐ mono
☐ chronic pain (back/neck)
☐ STD: type_____
☐ mental disorder: (bipolar, ocd) type_____
☐ anxiety
☐ depression
☐ eating disorder: type_____
☐ ADD/ADHD
☐ heart _____
☐ liver _____
☐ gallbladder _____
☐ kidney _____
☐ bladder _____
☐ gastrointestinal _____
☐ respiratory_____
☐ thyroid _____
☐ joint _____
☐ neuromuscular _____
☐ autoimmune _____
☐ other: _____

FEMALE HISTORY:

At what age did you start your periods? _____ years old
Periods are: ☐regular ☐irregular
How long do your periods last? _____days
Do you have ☐pain, ☐cramps or ☐heavy bleeding with your periods.
How old were you (if applicable), when you first had sexual intercourse? _____
Have you ever had a pelvic infection? ☐yes ☐no
Have you ever had an abnormal pap? ☐yes ☐no; Date of last pap: _____

Have your ever been pregnant?
# of pregnancies & dates:
_____
#of deliveries & dates:
_____
#of miscarriages/abortions & dates
_____

REVIEW OF SYSTEMS:

Check all of the following symptoms that you are experiencing TODAY:

GENERAL: ☐weight loss ☐weight gain ☐fatigue ☐body aches ☐fever ☐chills ☐night sweats

EYES:
☐vision loss
☐pain
☐itching
☐redness
☐drainage
☐double/blurred vision
last eye exam: _____

EARS:
☐pain
☐drainage
☐hearing loss
☐ringing in ears
☐congested
☐popping

NOSE:
☐bleeding
☐drainage
☐obstruction
☐sinus pain
☐post nasal drip
☐sneezing

MOUTH/THROAT:
☐hoarseness
☐difficulty swallowing
☐sore throat
☐sore/ulcer
☐tongue discoloration
☐painful tooth
last dental exam: _____

RESPIRATORY:
☐shortness of breath
☐wheezing
☐cough—sputum/blood
☐difficulty breathing
date of last chest x-ray_____

CARDIOVASCULAR:
☐chest pain
☐rapid heart rate
☐swelling in legs
☐palpitations
☐high blood pressure

URINARY:
☐frequency
☐urgency
☐burning
☐blood in urine
☐waking up to urinate

GASTROINTESTINAL:
☐stomach pain
☐nausea
☐vomiting
☐diarrhea
☐constipation
☐excess gas
☐indigestion/heartburn
☐poor or decreased appetite
☐vomit blood / blood in stool
☐hemorrhoids

BLOOD/LYMPH:
☐anemia
☐abnormal bleeding
☐enlarged lymph nodes

ENDOCRINE:
☐excessive thirst
☐excessive urination
☐heat/cold intolerance
☐excessive sweating

PSYCH:
☐problems with: sleeping/eating/pleasure
☐depression
☐anxiety

NEURO:
☐headaches
☐weakness
☐numbness
☐tremors
☐seizures
☐fainting

MUSCULOSKELETAL:
☐joint pain
☐swelling
☐deformity
☐backache
☐muscle pain
☐cramps

SKIN/BREAST:
☐rash
☐redness
☐sore
☐itching
☐dry skin
☐pain/lump

List location & description of any:
Tattoos: _____
Scars: _____
Ear/Body piercing: _____
_____

Reproductive:

Males: ☐sores ☐discharge from penis ☐hernia ☐testicular pain/mass

Females: ☐lower abdominal/pelvic pain ☐vaginal discharge (color _____); ☐odor; ☐rash; ☐itching

_____
NP/MD