



# UWSP Health Service Brief Medical History Form

## Demographic Information

Please fill out this section as completely as possible.

Name (Last, First, Middle Initial)

Birth Date

Last 4 Digits of SSN

Home Address (Box/House Number, Street, City, State, Zip)

Height (feet & inches)

Student ID Number

Birth State/Country & where you were raised

Weight (pounds)

### Gender

Female  Male

Occupation

Major

### Marital Status

Single  Widowed  
 Married  Separated  
 Divorced

### Race

Caucasian  Asian  
 African-Amer.  Hispanic  
 Native-Amer.  Other

Insurance Company & Policy Number (if applicable)

## Social History

Please fill out this section as completely as possible.

### Tobacco Use/Exposure

#### Smoking/Chewing

I do not smoke/chew  
 I do smoke/chew

#### Second Hand Smoke

Not regularly exposed  
 I am regularly exposed

### Alcohol Use

Drinks per week

### Exercise

Type

Number of years

Where exposure takes place

Drinks per evening

Frequency

Number per day

Amount of time

## Emergency Notification

Indicate the person to be notified in case of emergency, such as a parent or spouse.

Name (Last, First, Middle Initial)

Relationship to you

Home phone number

Work phone number

Cell phone number

## Family History

List any parents, grandparents, siblings or children who have had any serious illness or disease, including hospitalizations and mental illness.

Relationship	Age	Illnesses/cause of death
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

## Past Medical Care

List names, addresses and phone numbers of your primary care doctor or where you have received medical care in the past.

Name	Address	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

Turn Over ►►►

## Medical Issues

Indicate any medical issues you have had by placing a checkmark next to the issue.

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Diabetes                                 | <input type="checkbox"/> Bowel / Bladder abnormalities               | <input type="checkbox"/> Seizures                              |
| <input type="checkbox"/> Chest pain / Angina                      | <input type="checkbox"/> Asthma / Breathing difficulties             | <input type="checkbox"/> Implants                              |
| <input type="checkbox"/> High blood pressure                      | <input type="checkbox"/> Liver / Gallbladder problems                | <input type="checkbox"/> Dizziness / Fainting                  |
| <input type="checkbox"/> Heart disease / Heart attack             | <input type="checkbox"/> Sports or recreational related injuries     | <input type="checkbox"/> Recent surgeries / Recent fractures   |
| <input type="checkbox"/> Heart palpitations / Irregular heartbeat | <input type="checkbox"/> Stroke / CVA                                | <input type="checkbox"/> Positive reaction to a Tb (ippp) test |
| <input type="checkbox"/> High cholesterol                         | <input type="checkbox"/> Allergies to foods or latex                 | <input type="checkbox"/> Skin abnormalities                    |
| <input type="checkbox"/> Headaches / Migraines                    | <input type="checkbox"/> Abnormal pap smear                          | <input type="checkbox"/> Sexual transmitted infection/ HIV     |
| <input type="checkbox"/> Lack of energy or fatigue                | <input type="checkbox"/> Trouble concentrating                       | <input type="checkbox"/> Hernia or back problems               |
| <input type="checkbox"/> Urinary tract infection / Frequent UTI's | <input type="checkbox"/> Feelings of hopelessness/persistent sadness | <input type="checkbox"/> Gum disease                           |
| <input type="checkbox"/> Pregnancy / Miscarriage                  | <input type="checkbox"/> Depression, crying spells                   | <input type="checkbox"/> Pain or stiffness in your joints      |
| <input type="checkbox"/> Problems swallowing                      | <input type="checkbox"/> Mood changes or agitation                   | <input type="checkbox"/> Special diet guidelines               |
| <input type="checkbox"/> Burning in chest or stomach after meals  | <input type="checkbox"/> Sleep disturbances                          | <input type="checkbox"/> Other (specify below)                 |
| <input type="checkbox"/> Change in color of stools                | <input type="checkbox"/> Contemplated or thought about suicide       |  |

If you put a checkmark any issues above, briefly explain and give approximate date, duration of symptoms, and details:

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If you have any current physical restrictions, please list them:

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Please list any other information regarding your medical history that we should know about (including surgeries, serious illnesses or ongoing medical problems since childhood):

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## Medications

Indicate any medications that you presently take or that you take on a regular basis, including the dosage, time taken, and for what condition. Be sure to include prescription drugs, vitamins/dietary supplements, herbal remedies, and over-the-counter medicines (e.g., Tylenol).

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Please list any medications you are allergic to:

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## Immunizations

Indicate the month and year of each immunization series for the following that you have received.

_____ Td / Tdap (most recent)	_____ Varicella (series of 2)	_____ Hepatitis B (series of 3)
_____ Meningococcal meningitis (single injection)	_____ MMR (series of 2)	_____ HPV/Gardasil (series of 3)
	_____ Hepatitis A (series of 2)	

## Signature

By signing this form, you indicate that you have carefully answered all the above questions and affirm the accuracy of your answers.

Your signature \_\_\_\_\_

Date \_\_\_\_\_

INTERNAL USE ONLY

**Thank you for completing this form. This information is important to us in caring for you.**