

## RUTGERS UNIVERSITY STUDENT HEALTH SERVICES HEALTH HISTORY QUESTIONNAIRE

In order to provide you with more effective medical care, basic information is needed about your medical history. The time you spend completing this will be an important contribution to your overall health care.

Take whatever time you need and don't worry if you can't remember or aren't sure of the answer or any part of the question. Your health care provider will go over the form with you.

**THIS FORM IS CONFIDENTIAL AND IS NOT AVAILABLE TO ANYONE OUTSIDE OF THE RUTGERS UNIVERSITY HEALTH SERVICES WITHOUT YOUR WRITTEN PERMISSION**

NAME \_\_\_\_\_

Social Security/ID \_\_\_\_\_

**FAMILY HISTORY:** For each member of your family check boxes for:

1. Their present state of health
2. Any illness they have had

If deceased, write in age and cause of death. Include fatal accidents and suicides.

Family Member	Good Health	Poor Health	Deceased	Allergies	Anemia	Asthma	Diabetes	Cancer or Tumor	Epilepsy	Headaches	Sickle Cell Disease	Alcoholism	Problems with Drugs	Tuberculosis	Mental Health Problems	Sudden Death Before 50	High Blood Pressure	Heart Trouble	Stroke	Thyroid Problems	Cholesterol	
Mother																						
Father																						

**Allergy**

Any significant allergy to food, medications, latex, insects, pollen, or other allergens? .....  Yes  No

**Past Illnesses**

Please list significant past illnesses, such as Hepatitis and Mononucleosis, including childhood diseases:

**Medications**

Do you take any medications regularly, including herbals, supplements and over-the-counter drugs? .....  Yes  No

If yes, please list specific medications: \_\_\_\_\_

**Hospitalization**

Have you ever stayed overnight at a hospital? ...  Yes  No

Have you ever had surgery? .....  Yes  No

**Mental Health**

Any problems with your emotional health, requiring any form of therapy, including medication? .....  Yes  No

Do you feel you are having trouble managing your stress? .....  Yes  No

**Drug and Alcohol Usage**

Have you ever felt you should cut down on your drinking? .....  Yes  No

Have people annoyed you by criticizing your drinking? .....  Yes  No

Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? .....  Yes  No

Please give specific information about drug usage in the past as well as current:  
\_\_\_\_\_  
\_\_\_\_\_

**Miscellaneous**

Did you ever lie to anyone about your gambling? .....  Yes  No

Does anyone presently in your life hurt you or make you feel afraid? .....  Yes  No

(OVER)

**Eye, Ear, Nose and Throat**

Any problems with your eyes, ears, nose or throat?

Yes No

**Health and Nutrition**

Are you following a special diet? .....  
If yes, which diet and why?

Yes No

**Cardiovascular**

- Heart Murmur?.....
- Chest Pain? .....
- Rheumatic Fever? .....
- High Blood Pressure?.....
- Irregular Heartbeat?.....
- Phlebitis or Blood Clots (except menstrual clots)?.....

Any current or history of eating disorder ?

Does concern about your weight affect your behavior or mood?.....

Have you gained/lost 10 lbs in the past year? .....

Do you exercise regularly? .....

**Respiration**

- Asthma? .....
- Chest Infections? .....
- Do you smoke cigarettes? .....
- How many \_\_\_\_\_ day for \_\_\_\_\_ years
- If yes, do you want to quit? .....
- Do you chew tobacco? .....

**Digestive**

Any problems with any part of your intestinal tract or stomach?.....

**Skin**

Any problems with your skin?.....

**Neurology**

Have you had seizures or convulsive disorder, blackouts, fainting spells, or recurrent headaches?

**Endocrine**

- Thyroid Disease? .....
- Diabetes? .....

**SEXUAL HISTORY**

Have you ever been sexually involved with another person?

Yes  No

If yes, age at first encounter: \_\_\_\_\_

If yes, your partners are or have been:

Female  Male  Both

Do you use condoms?

Always  Sometimes  Never  N/A

Other contraception?

Always  Sometimes  Never  N/A

Which other contraception?

Have you ever had a sexually transmitted disease: (e.g. Herpes, Warts, Chlamydia, Gonorrhea, HIV (AIDS Virus), Syphilis)? Please circle the ones you have had.

Yes  No

History of pregnancy Yes  No

Number of children \_\_\_\_\_

**Urinary**

- Problems with any part of your urinary tract or kidney? .....
- Any recurrent urinary tract infections? .....
- Frequency or burning of urination? .....

**Blood**

Any blood abnormality (such as anemia)?

**Rutgers University Health Services supports patient's right to access medical records and ensures patient confidentiality and privacy**

For Staff Use Only			
Initials	Date	Initials	Date
_____	_____	_____	_____
_____	_____	_____	_____