University of Wisconsin Oshkosh Student Health Center **HEALTH HISTORY** ☐ **NEW PATIENT** ☐ **PHYSICAL**

NAME:	☐ Man ☐ Woman ☐ Transgender	ID#:
PREFERRED NAME:	Email Address:	
Local Address (include city, state & zip):	Birth date:	
Cell Phone: / Cell Carrier:	**Current Prescribed Medications** *(list all including birth control)*	

ALLERGIES	**What is reaction?**	**Medication**	**Dosage (if known)**

HOSPITALIZATIONS/SURGERY (List All)		**Current Herbal/Vitamins or Non-Prescribed Medications**	
Year	**Reason:**	**Medication**	**Dosage (if known)**

Whom do you want notified in case of an emergency?

Name: Relationship:

Home Phone: Work Phone: Cell Phone:

Health	Yes	No		Yes	No			
Do you smoke cigarettes?			Use smokeless tobacco?			If yes, how many/day?		# years:
Do you want to quit?			# of Quit Attempts:					
Do you use street drugs?			If yes, what type?			If yes, how often?		
Do you drink alcohol?			Have you felt you needed to cut down?			If yes, how many drinks per week?		
Do you exercise regularly?			If yes, what type?			If yes, how often?		
Do you use seat belts regularly?								

Any questions or concerns regarding any of the following:	Yes	No		Yes	No
Family alcoholism or drug abuse?			Your appearance, weight or nutrition?		
Rape, sexual abuse or unwanted sexual activity?			Dating/Domestic violence or stalking?		
Termination of pregnancy (you or partner)?					

During the past month, have you felt sad, lonely, down, depressed or hopeless?	Frequently	Rarely	Never
During the past month, have you felt little interest or pleasure in doing things?	Frequently	Rarely	Never

FAMILY HEALTH HISTORY	**Mom**	**Dad**	**Sibling**	**FAMILY HEALTH HISTORY**	**Mom**	**Dad**	**Sibling**
Alcoholism				High blood pressure			
Drug abuse				High cholesterol			
Blood or clotting disorder				Cancer/type:			
Depression/psychiatric illness							
Diabetes				Hereditary disease			
Stroke				Tuberculosis			
Heart disease				Sudden unexpected Death before age 50			
Thyroid Problems				Other serious illness			

PERSONAL HISTORY: Have you had or do you now have:

Head/Neurologic	Past	Present	**Heart/Circulation/Chest**	Past	Present	**Genitourinary**	Past	Present
Headaches- occasional			Severe chest pain/pressure			Urinary/kidney Problem		
Migraine:			Heart disease or murmur			Frequent Bladder Infection		
Circle: Rare / Occasional / Frequent			Rapid or irregular pulse			**Chronic Diseases**		
			Blood clots/vein problems			Diabetes		
			Respiratory			Asthma		
Dizziness or fainting			Chronic cough > 1 month			High blood pressure		
Loss of consciousness			Pneumonia			Arthritis		
Head injuries			Tuberculosis or + PPD			Sickle cell disease		

	Past	Present		Past	Present		Past	Present
Eyes			Shortness of breath			Seizures or Epilepsy		
Vision or eye problems			**Gastrointestinal**			Thyroid Disease		
Glasses/contact lenses			Abdominal pain			Elevated Cholesterol		
Last eye exam (year):			(severe/recurrent)			Obesity		
Ears/Nose/Throat			Heartburn			**Psychiatric**		
Allergies or hay fever			Ulcer			Anxiety		
Ear or hearing problems			Hepatitis			Depression		
Frequent sinusitis			Stomach/Bowel movement			Bipolar		
Dental problems			problems			Other mental health concerns		
Last dental exam (year):			Gallbladder disease			**Additional Medical History**		
Skin			Hernia			ADD/Learning disability		
Severe acne or skin disorder			**Musculoskeletal**			Cancer		
New or changing moles			Swollen or painful joints or			Eating Disorder		
Blood Disorder			extremities			Unusual Fatigue > 1 month		
Anemia			Chronic or severe back problems			Recent gain or loss of weight > 10		
Bleeding disorder						pounds		
Enlargement of glands or lymph nodes			**Other**			**Other**		

Explain all "Yes" answers from above:

Sexual Health If N/A, skip to next section

If sexually active how long have you been sexually active?		Anal Oral Vaginal (circle)		Last sexual encounter:	
Number of lifetime partners:		Number of months with current partner:		Have your sexual partners been: (circle) Male Female Both	
Have you ever had an STD?	Yes No	Last STD screen (m/d/y)		HPV Vaccine 1 2 3 None (circle)	

If yes, circle all that apply: Chlamydia Gonorrhea HPV/Genital Warts Genital Herpes HIV Other:

Are you presently using a method of birth control: (circle) Pill Ring Depo Plan B Condom None Other:

Are you aware that emergency contraception (morning after pill) is available for women? Yes No

WOMEN'S HEALTH (women answer only)	Y	N			Have you ever had or do you now have:	Past	Present
Do you have monthly periods?			Last Period: (mo/day/yr)		Breast lumps or discharge		
Have you ever been pregnant?			If yes, when? (m/d/y)		Ovarian cysts or endometriosis		
Complications?			If yes, what?		Vaginal infections or abnormal discharge		
How many live births?			How many miscarriages?		Pain or bleeding with intercourse or outercourse		
How many terminations?							
Was your last pap normal?			Date of last pap: (m/d/y)				
Do you have a history of abnormal paps?			If yes, when? (m/d/y)				
Have you had any special procedures because of an abnormal pap?			If yes, when? (m/d/y)		Have you had education about breast self- examination (BSE)?		

MEN'S HEALTH (men answer only)	Past	Present		Past	Present
Do you have any penile discharge or change in urination?			Have you ever had undescended testicles, testicular problems or cancer?		
Have you ever had prostate problems?			Do you regularly examine your testicles for swelling or lumps?		

TRANSGENDER HEALTH					
Hormone Therapy			Male to Female Surgery		
Female to Male Surgery					

Student's Signature: **Date:**

Provider comments:

Reviewed by: **Date:**