KU WATCHINS HEALTH SERVICES
The University of Kansas

HEALTH HISTORY FORM

Watkins Health Center
1200 Schwegler Drive • Lawrence, KS 66045
785-864-9500 • FAX: 785-812-0213
www.studenthealth.ku.edu

Name:_____ **KU ID#:**_____ **Date of Birth:** _____

MEDICATION HISTORY ☐ No Current Medications

Include all prescriptions, birth control, over-the-counter meds, vitamins, supplements, and herbal preparations that you take.
Name of Medication, including dosage and frequency (example: 250 mg, one tab, twice daily)

_____

_____

FOOD / MEDICATION / MATERIAL ALLERGIES (Include all substances: penicillin, latex, peanuts, etc.)

☐ **No Known Food/Medication/Material Allergies**

Name of Food/Medication/Material	Type of Reaction	Approx. Date of Onset

PERSONAL/PAST MEDICAL HISTORY ☐ *No Significant Personal Medical History*, Please select all that apply:

____ Acid Reflux/GERD
____ Anemia
____ Anxiety Disorder
____ Asthma
____ Attention Deficit (ADD/ADHD)
____ Bipolar Disorder
____ Cancer/Type: _____
____ Concussion
____ Clotting Disorder
____ Depression
____ Diabetes
____ Eating Disorder
____ Hay Fever/Allergies
____ Hearing Impairment
____ Heart Disease
____ Heart Murmur
____ Hepatitis B or C
____ High Blood Pressure
____ High Cholesterol
____ HIV Infection
____ Liver Disease
____ Mononucleosis
____ Migraine Headaches
____ Palpitations
____ Seizures
____ Other: _____
____ Sexually Transmitted Infection
____ Sickle Cell Trait
____ Substance/Alcohol Use:
☐ Alcohol (drinks/week)_____
☐ Tobacco Use ( )Former ( )Current
Packs per day_____
☐ Marijuana Use_____
☐ E-cig (# cartridges/week) _____
☐ Other Recreational Drugs ( )Yes ( )No
____ Suicidal Thoughts/Attempts
____ Thalassemia
____ Thyroid Disorder
____ Urinary/Kidney Problems

Parents & Siblings Medical History

☐ No Significant Family History
____ Alcohol/Substance Abuse
____ Cancer: _____
____ Clotting Disorder
____ Depression
____ Diabetes
____ Heart Disease
____ High Blood Pressure
____ High Cholesterol
____ Thyroid Disorder
____ Other: _____

What do you use for STI (sexually transmitted infection) protection? _____

HOSPITALIZATION / SURGICAL HISTORY *(include dates)* ☐ No Past Hospitalizations/Operations

Condition(s): _____

_____

TO BE COMPLETED IF APPLICABLE

1. □Yes □ No Do you skip periods?
2. □Yes □ No Have you had irregular bleeding?
3. □Yes □ No Have you had Recurrent vaginal infections?
4. Contraception: *Check method used in the past and currently.*
   □ past □ now Oral contraceptives — If used, what type of pill? _____
   □ past □ now Depo Provera □ past □ now Condoms □ past □ now Spermicide
   □ past □ now Birth Control Implant (Nexplanon/Implanon) □ past □ now IUD — Brand: _____
   Other (specify):_____
   How long was each method used?_____
   Were there any problems? _____
5. Date of last pelvic exam: _____
6. Date of last Pap smear: _____ Was it normal? □Yes □ No
7. Date of last menstrual period: _____
8. Number of pregnancies: _____ Number of live births:_____
9. Have you had GYN surgery? □Yes □ No If yes, give date and describe: _____

Patient Signature:_____ Date: _____

********** *DO NOT WRITE BELOW THIS LINE – FOR INTERNAL USE ONLY* **********