FORT HAYS STATE UNIVERSITY
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STUDENT HEALTH CENTER

Name:	Best Phone:	Today's Date:
☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		DOB:

Financial responsibility for today's visit: ☐ Self ☐ Parent ☐ Other _____

Send Statements to:

Name: _____ Phone: _____

Address _____ City/ST/Zip _____

Tell us why you are here today:

My health history, symptoms and information for today's visit

1. My General Health Status

YES	NO	
☐	☐	My Health is generally good
☐	☐	Recent weight gain or loss (>25 lbs.)
☐	☐	Frequent colds, flu, etc.
☐	☐	Chronic fatigue (> 6 months)
☐	☐	Cancer_____
☐	☐	Genetic Condition

2. I've had the following Immunizations

YES	NO	
☐	☐	Hepatitis B
☐	☐	Vaccine/shot for Rubella/MMR
☐	☐	Tetanus Vaccine shot
☐	☐	Meningitis
☐	☐	Gardisil

3. My Cardiovascular Health Status

YES	NO	
☐	☐	Heart Disease/Murmur
☐	☐	High Blood Cholesterol/Triglycerides
☐	☐	High Blood Pressure
☐	☐	Thrombophlebitis/Blood Clots in veins or lungs
☐	☐	Sub-Acute Bacterial Endocarditis

4. My Neurological Health Status

YES	NO	
☐	☐	Stroke
☐	☐	Migraine (Diagnosis by MD)
☐	☐	Sensory difficulties (numbness, hearing, taste, smell)
☐	☐	Seizures/Epilepsy

5. My Gastrointestinal Health Status

YES	NO	
☐	☐	Stomach/bowel problems
☐	☐	Liver disease/jaundice
☐	☐	Hepatitis
☐	☐	Gall Bladder disease

6. My Endocrine Health Status

YES	NO	
☐	☐	Diabetes/Diabetes of pregnancy
☐	☐	Thyroid problems

7. My Respiratory Health Status

YES	NO	
☐	☐	Asthma
☐	☐	Chronic Cough
☐	☐	Other breathing problems

8. My Genitourinary Health Status

YES	NO	
☐	☐	Frequent bladder infections (>3 per year)
☐	☐	Bladder, urinary or kidney problems
☐	☐	Abnormal pap smear
☐	☐	Abnormality of uterus
☐	☐	Pelvic Infection/Pain/PID
☐	☐	Recurrent vaginal infections
☐	☐	Sexually transmitted disease: Chlamydia/Gonorrhea/Herpes Syphilis/Genital Warts/Other
☐	☐	Breast Problems: Discharge/ Disease/Tumor/Surgery

9. My Hematologic Health Status

YES	NO	
☐	☐	Anemia
☐	☐	Blood clotting disorder
☐	☐	Blood transfusion
☐	☐	Sickle Cell Anemia/Trait/ Thalassemia/PKU

10. My Dermatological Health Status

YES	NO	
☐	☐	Acne
☐	☐	Chronic rash/itching
☐	☐	Other skin problems

11. Musculoskeletal

YES	NO	
☐	☐	Arthritis
☐	☐	Broken bones/fractures

12. Eyes

YES	NO	
☐	☐	Eye problems (other than glasses)

13. Ears / Nose / Throat / Mouth

YES	NO	
☐	☐	Hearing Problems
☐	☐	Frequent nosebleeds
☐	☐	Frequent sore throat
☐	☐	Teeth/Gum Problems

14. My Mental Health Status

YES	NO	
☐	☐	Depression
☐	☐	Anxiety
☐	☐	Severe mood swings
☐	☐	Under care of psychiatrist / psychologist

Please complete the question on the back of this page

Name:_____ DOB:_____

Health History (to be completed annually)

Do you take any medications? ☐ YES ☐ NO (If YES, indicate below.)

☐ Prescription Medication ☐ Vitamins ☐ Over the counter medications ☐ Birth Control Pills ☐ Other Drugs

Do you have any allergies? ☐ YES ☐ NO (If YES, indicate below.)

☐ Medications ☐ Seasonal allergies/Hay fever ☐ Insect bites or stings ☐ Foods ☐ Other

Have you had a major trauma, serious illness or had surgery? ☐ YES ☐ NO

Are you currently under the regular care and treatment by another physician or medical providers? ☐ YES ☐ NO

Have you been threatened, hurt or frightened by someone in your current relationships? ☐ YES ☐ NO

Are you sexually active? ☐ YES ☐ NO (If YES, indicate below.)

Multiple partners this year? ☐ YES ☐ NO Partners were: ☐ Male ☐ Female

Any history of a sexually transmitted infection? ☐ YES ☐ NO ☐ NOT SURE

Do you smoke or use tobacco? ☐ YES ☐ NO Frequency? ☐ Daily/regularly ☐ On occasion ☐ Quit

Do you use alcohol? ☐ YES ☐ NO Frequency? Avg. drinks/day: _____ or Avg. drinks/wk _____

Do you use any illegal drugs? ☐ YES ☐ NO Frequency? ☐ Regularly ☐ On occasion

Do you exercise? ☐ YES ☐ NO Frequency? ☐ Regularly ☐ On occasion

Has anyone in your immediate family had:
(Indicate be circling M = Mother F = Father S = Sister B = Brother O = Other relative)

Heart disease M F S B O High blood pressure M F S B O Diabetes M F S B O

Cancers M F S B O Genetic disorder M F S B O ☐ Don't know

Female Patients

Age periods started _____ HPV Vaccine (Gardisil)? ☐ YES ☐ NO Ovarian Cysts? ☐ YES ☐ NO

Heavy Menses? ☐ YES ☐ NO Pregnant now? ☐ YES ☐ NO ☐ NOT SURE Breastfeeding now? ☐ YES ☐ NO

Previous Pap? ☐ YES ☐ NO When: _____ Was it normal? ☐ YES ☐ NO

I, hereby consent to treatment at the Student Health Center.

_____ _____

Student's Signature Date

Clinician Signature _____ Date_____