

The University of Chicago Hospitals
Student Care Center
Initial Health History Student ID Number _____

Please answer the following questions as completely as possible. This information is confidential and will be retained in your chart for future visits.

Patient Sticker or

Patient Name

Medical Record Number

Date

1. What are your concerns about your health today or the purpose of your visit?

2. Medical /Surgical History-List all previous major illnesses, injuries, surgeries, or hospitalizations. Include any condition for which you currently take or previously took prescription medication regularly.

Condition	Date(s) Treated

3. Medications- List your current medications. Include all vitamins, supplements, herbal medications, and birth control pills.

Medication	Dose	When Taken

4. Allergies - Describe any medication, chemical, or food allergies.

Medication/Food	Describe your reaction

5. Health Screening	Date of last exam
Cholesterol Test	
Complete physical	
Colon Cancer Screening	
Dental exam	
Eye Exam	
HIV Test	
Mammogram	
Prostate Cancer Test	

6. Vaccinations	Date
Chicken Pox (Varicella)	
Hepatitis A	
Hepatitis B	
Polio	
Tetanus	
Typhoid	
Yellow Fever	

7. Family History-Check all conditions found in your blood relatives and list their age at onset						
Condition	Father	Mother	Sibling	Aunt/Uncle	Grandparent	Other-Specify
Heart Disease						
Diabetes						
High Blood Pressure						
High Cholesterol						
Cancer-indicate type						
Thyroid Disease						
Allergies						
Asthma						
Mental Health-Depression, etc...						
Other: _____						

8. Social History					
1. What is your program of study?	_____				
2. Who do you currently live with?	_____				
3. Do you work?	<input type="checkbox"/> No	<input type="checkbox"/> Yes, what kind of work do you do?	_____		
4. Have you ever used tobacco?	<input type="checkbox"/> No	<input type="checkbox"/> Yes, how much/for how long?	_____		
5. Do you currently use tobacco?	<input type="checkbox"/> No	<input type="checkbox"/> Yes, how much/how often?	_____		
6. Have you used marijuana or other drugs?	<input type="checkbox"/> No	<input type="checkbox"/> Yes, which drugs and how often?	_____		
7. Do you drink alcohol?	<input type="checkbox"/> No	<input type="checkbox"/> Yes, how many drinks per week on average?	_____		
8. Do you exercise regularly?	<input type="checkbox"/> No	<input type="checkbox"/> Yes, which kinds of exercise/how often?	_____		
9. Do you use seatbelts?	<input type="checkbox"/> No	<input type="checkbox"/> Yes			
10. Do you use a bicycle helmet?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Not applicable		
11. Do you follow any particular diet?	<input type="checkbox"/> No	<input type="checkbox"/> Yes, describe	_____		
12. Have you ever been in a physically frightening or hurtful relationship?	<input type="checkbox"/> No	<input type="checkbox"/> Yes			
13. Do you have any personal or sexual problems that you would like to discuss?	<input type="checkbox"/> No	<input type="checkbox"/> Yes			
14. How would you rate your overall health?	Excellent	Very Good	Good	Fair	Poor

10. REVIEW OF SYSTEMS-CHECK ALL THAT APPLY

General

- Weight Change
- Appetite Change
- Difficulty Sleeping
- Other _____

Skin

- Rashes
- Itching
- Other _____

Endocrine/Metabolic

- Diabetes
- Thyroid Problems
- Infertility
- High Cholesterol
- Other _____

Eyes/Ears

- Change in vision
- Glaucoma
- Hearing Loss
- Cataracts
- Other _____

Nose and Throat

- Allergies
- Bloody Noses
- Sore Throat
- Hoarseness
- Teeth Problems
- Congestion
- Sinus Problems
- Other _____

Heart

- Chest Pain
- Heart Murmur
- High Blood Pressure
- Feet and Ankle Swelling
- Abnormal Heart Rhythm
- Other _____

Lungs

- Shortness of Breath
- Cough
- Asthma
- Exposure to Tuberculosis
- Tuberculosis
- Other _____

Stomach/Intestines

- Heartburn/Indigestion
- Difficulty Swallowing
- Ulcers
- Blood in stool
- Black Bowel Movements
- Constipation
- Incontinence(loss of control) of Stool
- Frequent Laxative Use
- Gallbladder Problems
- Diarrhea
- Other _____

Kidneys/Bladder

- Burning/Pain with Urination
- Blood in Urine
- Sexually Transmitted Diseases
- Urinating Frequently
- Frequent Urinary Tract Infections
- Incontinence (loss of control) of Urine
- Other _____

Nervous System

- Headaches
- Dizziness
- Loss of Consciousness/Passing out
- Numbness and Tingling
- Seizures
- Other _____

Muscles and Joints

- Joint Pain
- Joint Stiffness
- Back Pain
- Other _____

Mood

- Anxiety/Nervousness
- Depression
- Eating Disorder
- Panic Attacks
- Have seen a psychiatrist
- Other _____

Clinician Signature _____

Date Reviewed _____