CAMPUS HEALTH CLINIC:
CONFIDENTIAL HEALTH HISTORY QUESTIONNAIRE

PURDUE UNIVERSITY FORT WAYNE
Campus Health Clinic

Campus Health Clinic
Walb Student Union, Room 234
Purdue University Fort Wayne
2101 E. Coliseum Blvd
Fort Wayne, IN 46805-1499

Phone: 260-481-5748
Fax: 260-481-5752

Name_____ **Age**_____ **Date**_____

Give a brief statement of your general health_____
(Excellent, Good, Fair, Poor)

If you check yes to any question below, describe problems in detail.	YES	NO	Details of Medical History
1. Do you have any current medical problems?	❑	❑	_____
2. Does your health prevent you from participating in any physical activities?	❑	❑	_____
3. Have you had any chronic illnesses, serious illnesses or physical disabilities?	❑	❑	_____
4. Have you ever been under the care of a psychologist, psychiatrist, or counselor?	❑	❑	_____

HOSPITALIZATIONS/SURGERY/BROKEN BONES	
YEAR	**REASON**
	Have you ever been advised to have any surgical operation that has not been performed?

ALLERGIES: List Medication and Other Allergies if applicable	**CURRENT MEDICATIONS:** List **ALL** medications including birth control, over-the-counter, and herbal medications or supplements. Give dosages and reason for taking medication		
	Medication	**Dose**	**Why you are taking medication**

Physicians	**Phone Number**	**Address**
Primary Care Provider:		
OB GYN:		
Specialist:		

Please Complete Other Side of Form

PAST MEDICAL HISTORY: Have you or your immediate family (mother, father, sibling, or child) ever been told you have had:

CONDITION	YES	NO	FAMILY	CONDITION	YES	NO	FAMILY
Abdominal pain				Indigestion/Heartburn			
Anemia				Infertility			
Anxiety				Insomnia			
Arthritis				Kidney disease			
Asthma				Leg pain/swelling			
Back pain				Measles			
Bladder infections				Menstrual dysfunction			
Bleeding tendency				Mental health issues			
Blood transfusion				Mumps			
Bowel irregularity				Neck pain			
Bursitis/tendonitis				Osteoporosis			
Cancer				Pneumonia			
Chest pain				Polio			
Chickenpox				Prostate problems			
Chronic rash				Rectal bleeding			
Circulation problems				Ringing in the ears			
Depression				Sexual dysfunction			
Diabetes				Shortness of breath			
Dizziness/Fainting				Sleep apnea			
Epilepsy/Seizures				STD			
Erectile Difficulties				Stroke			
Fatigue				Tetanus			
Gallbladder disease				Thyroid disease			
Glaucoma/Cataracts				Tuberculosis			
Headaches/Migraines				Ulcer			
Hearing loss				Weakness			
Heart disease				Weight gain			
Heart murmurs				Weight loss			
Heart palpitations				Wheezing			
Hemorrhoids				Whooping Cough			
Hepatitis				Other problems:			
Hernia							
High/Low blood pressure							
HIV/AIDS							
Hives							
COMMENTS: Please explain all YES responses:							

SOCIAL HISTORY

	YES	NO	COMMENTS		YES	NO	COMMENTS
Do you live alone?				Are you employed?			
Do you have children?				Do you exercise?			
Do you drink alcohol?				Do you smoke?			
Do you drink caffeinated beverages?				Are you under more than normal stress?			
Do you take prescribed medications?				Other:			