

Sample Health History Form

Your health history includes the following areas:

- Past or Ongoing Health Issues
 - Medications
 - Surgery, significant injuries, hospital stays
 - Cholesterol
 - Height/weight
 - Family History
 - Miscellaneous
 - Women's Health (Women Only)
-

Past or Ongoing Health Issues:

Allergies

- Allergic reaction requiring urgent medical care
- Food allergy requiring urgent medical care
- Nasal allergies

Cancer Risk Factors

- Cancer (Please explain below)
- Tobacco use

Cardiovascular

- Bleeding disorder
- Blood clot in deep vein
- Heart disease
- Heart murmur
- Heart rhythm problem
- High blood pressure
- High cholesterol

- Inflamed blood vessel
- Mitral valve prolapse
- Need for antibiotics before procedures (SBE pre.)
- Pulmonary embolism
- Stroke

Endocrine

- Diabetes, type 1
- Diabetes, type 2
- Thyroid disease

GI / Liver

- Crohn's disease
- Gall bladder disease
- Gastroesophageal reflux disease (GERD)
- Hepatitis
- Liver disease
- Sickle cell disease or trait
- Stomach ulcers
- Ulcerative colitis

Gynecological

- Breast problem
- Endometriosis
- Irregular periods (Greater than 45 days)
- Ovarian cyst
- Painful periods
- Polycystic ovary syndrome (PCOS)
- Urine / tubal infection (PID)
- Uterine fibroid

Hematology

- Anemia

Kidney

- Kidney disease
- Kidney infection
- Recurrent urinary tract infections

Mental Health

- Alcohol addiction
- Attention deficit disorder
- Depression
- Drug addiction
- Eating disorder
- Generalized anxiety disorder

Miscellaneous

- Hearing impairment
- Irritable bowel syndrome
- Migraine headaches
- Mobility impairment

Neurological

- Chronic headaches
- Seizure disorder
- Respiratory
- Asthma

Tuberculosis Risk Factors

- Positive TB test
- Tuberculosis

Please explain any items you have checked in the comment section below.
Also, include any additional significant illnesses.

Medications:

Please list all medications you take regularly (including birth control pills and non-prescription drugs).

Name of Medication	Dosage of Medication
1	1
2	2
3	3
4	4
5	5
6	6
7	7

Please list any allergic or other significant reactions to medication.

Name of Medication	Type of Reaction	Approx Date of Onset
1	1	1
2	2	2
3	3	3
4	4	4
5	5	5
6	6	6
7	7	7

Surgery, significant injuries, hospital stays:

Please list any surgery, significant injuries, and hospital stays, with dates.

Description	Approximate Date
1	1
2	2
3	3
4	4

Cholesterol:

Have you had your cholesterol checked?

- Yes, number if known:
- No

Height/weight:

What is your height? Circle Units: in cm

What is your weight? Circle Units: lbs kg

Family History:

Are you adopted?

- Yes
- No

Please complete for all biological family members and include heart disease, high cholesterol, diabetes, high blood pressure, tuberculosis, stroke, alcoholism, depression, other mental illness, cancer (specify type).

Please provide health history information for your biological relatives.

If you were adopted and do not know the health histories of your biological relatives, that is fine. In that case, please proceed to the next section.

Father

Year of Birth:

Age at Death (if deceased):

Cause of Death (if deceased):

Occupation:

Medical Problem 1:

Approx Onset Date:

Comment:

Medical Problem 1:

Approx Onset Date:

Comment:

Medical Problem 1:

Approx Onset Date:

Comment:

Mother

Year of Birth:

Age at Death (if deceased):

Cause of Death (if deceased):

Occupation:

Medical Problem 1:

Approx Onset Date:

Comment:

Medical Problem 1:

Approx Onset Date:

Comment:

Medical Problem 1:

Approx Onset Date:

Comment:

Sibling 1

Year of Birth:

Sex: Male Female

Age at Death (if deceased):

Cause of Death (if deceased):

Occupation:

Medical Problem 1:

Approx Onset Date:

Comment:

Medical Problem 1:

Approx Onset Date:

Comment:

Medical Problem 1:

Approx Onset Date:

Comment:

Sibling 2

Year of Birth:

Sex: Male Female

Age at Death (if deceased):

Cause of Death (if deceased):

Occupation:

Medical Problem 1:

Approx Onset Date:

Comment:

Medical Problem 1:

Approx Onset Date:

Comment:

Medical Problem 1:

Approx Onset Date:

Comment:

Sibling 3

Year of Birth:

Sex: Male Female

Age at Death (if deceased):

Cause of Death (if deceased):

Occupation:

Medical Problem 1:

Approx Onset Date:

Comment:

Medical Problem 1:

Approx Onset Date:

Comment:

Medical Problem 1:

Approx Onset Date:

Comment:

Sibling 4

Year of Birth:

Sex: Male Female

Age at Death (if deceased):

Cause of Death (if deceased):

Occupation:

Medical Problem 1:

Approx Onset Date:

Comment:

Medical Problem 1:

Approx Onset Date:

Comment:

Medical Problem 1:

Approx Onset Date:

Comment:

Women's Health (Women Only):

Have you ever had a Pap test?

Yes

No

Date of your most recent Pap test or pelvic exam:

Any abnormal finding? (please explain)

Number of menstrual periods in the last 12 months:

Miscellaneous:

Primary physician's name:

Primary physician's phone number:

DO NOT MAIL THIS FORM TO UHS/PENN STATE.

YOU MUST ENTER THIS INFORMATION ON THE UHS SECURE WEB SITE.