

Personal Health History

Please mail in an envelope marked "confidential" to:

OHSU
Joseph B. Trainer Student Health Service
3181 SW Sam Jackson Park Road, L587
Portland, OR 97239-3098

Med Record Number (If known) _____

NAME: _____

BIRTHDATE: _____

Soc. Sec. No: _____

Sex: Male _____ Female _____

Birthplace _____

Number of years lived in USA _____

This form is filed in the Student Health Service as part of your confidential medical record. (Please print)

Program _____ Date Entering School _____ Date you anticipate graduating _____

Local Address _____ City _____ State _____ Zip _____

Phone _____ Email _____

Single _____ Married _____ (Spouse's Name _____)

Divorced/widowed _____ Domestic Partner (Name _____)

In case of emergency contact: _____ (_____) _____
Name (Relationship) (Area code) (Phone)

MEDICAL HISTORY

- 1) Injuries/Surgeries/Illnesses:
- 2) Hospitalizations (other than for surgery listed above):
- 3) Chronic medical problems:
- 4) For Women: Last Pap smear _____ Any history of abnormal Pap? Yes ___ No ___
(Date)
- 5) Have you ever been in a country outside the USA? Yes ___ No ___
If yes, which countries and for how long?
- 6) Medications you are presently taking (including birth control, over the counter medications, supplements and topical medications).
- 7) Are you allergic to any medications? Yes ___ No ___
If you are allergic to medication, please list the names of those medications and your reaction.
- 8) Do you have any other allergies? Yes ___ No ___ Please list.
- 9) Do you use tobacco? _____ Have you ever used tobacco? _____
- 10) How much alcohol do you consume per week?
- 11) Have you ever been physically, emotionally, or verbally abused?

NAME _____

DATE OF BIRTH _____

12) Other: (Give details below including type of condition and relationship of family members)

	You	Family		You	Family
Alcohol/Drug Problem			Head and Neck Radiation Therapy		
Anemia			Heart Disease		
Arthritis			High Blood Pressure		
Asthma			High Cholesterol		
Birth defect			Kidney Disease		
Bladder infections			Liver Disease		
Bowel Problems			Rheumatic Fever		
Cancer			Seizures		
Counseling			Sexually Transmitted Disease		
Diabetes			Thyroid Disease		
Eating Disorders			Ulcers (Stomach)		
Emotional Problems			Other (specify)		
Genital Herpes					
Headaches					

If you have a chronic illness that has required on-going care, we suggest you request records be sent to the Student Health Service and that you make an appointment at the Student Health Service to continue care.

13) Stresses (e.g., death in family, divorce, etc.) Dates?

We recommend these LIFESTYLE BEHAVIORS:

- 1) Exercise regularly (30 minutes per day).
- 2) Wear safety belt, bike helmets, etc. when appropriate.
- 3) If you are sexually active, practice safer sex.
- 4) For women: monthly breast self-exam.
For men: monthly testicular self-exam.
- 5) If you choose to have a firearm, use safe locked storage.
- 6) If you use tobacco, consider quitting. If you need help, ask us.
- 7) If you drink alcoholic beverages, drive responsibly. Always use a designated driver.
- 8) Low fat diet with 5-9 servings of fruits and vegetables per day.
- 9) Use sunscreens of SPF 15 or greater.
- 10) Pace yourself each day, and balance your work/studies with fun, friends, and family.
- 11) Any questions, concerns, please ask!

Signed: _____ Date _____