Student Health Services
University of South Carolina

HEALTH HISTORY FORM

Form must be filled out before your appointment time
Please be sure all information is complete.

_____
Today's Date

_____
Student's name (Last, First, Middle Initial)

_____
Emergency Contact Name Relationship

_____
Student's mailing address while at school City State ZIP

_____
Student's permanent mailing address

_____
Student's email address Preferred Phone (Cell #)

_____
City State ZIP Phone #

_____
Date of Birth SSN#

Have you completed a living will or
power of attorney for healthcare? _____

ALLERGY HISTORY

List any drug allergies: _____ Reaction: _____

List any allergies to materials (such as latex): _____ Reaction: _____

List any food allergies: _____ Reaction: _____

List any allergies to insects/other: _____ Reaction: _____

Are you receiving allergy injections? _____

CURRENT MEDICATIONS

List any drugs, medications, birth control, vitamins, and dietary supplements you currently use:

_____
_____

PERSONAL HISTORY

Indicate whether you have had any of the following medical issues:

General Medical Health Problems	Y	N
Acne	○	○
Anemia	○	○
Anxiety	○	○
Asthma/Lung disease	○	○
Bleeding problem	○	○
Blood clots in legs or lungs	○	○
Broken bones	○	○
Cancer	○	○
Cerebral palsy	○	○
Chicken pox	○	○
Colitis, ulcerative/Crohn's disease	○	○
Concussion	○	○
Congenital defect	○	○
Diabetes	○	○
Epilepsy, seizures	○	○
Hearing loss	○	○
Heart murmur/other heart problems	○	○
Hepatitis	○	○
High blood pressure	○	○
High cholesterol	○	○
Irritable bowel	○	○
Kidney infection, stones	○	○
Migraine headaches	○	○
Mononucleosis	○	○
Pneumonia	○	○
Rheumatic fever	○	○
Rheumatoid, other arthritis	○	○
Seasonal allergies	○	○
Scoliosis	○	○
Sickle cell	○	○
Thyroid problems	○	○
Tuberculosis or positive PPD	○	○
Ulcers	○	○

If yes to any of the above, please explain:

_____
_____
_____

SOCIAL HISTORY

TOBACCO
Do you smoke cigarettes?
- O Yes
- O No

If yes, how many packs per day?
# of packs _____

If yes, how many years?
# of years _____

ALCOHOL/DRUG USE
Do you drink alcohol?
- O Yes
- O No

If yes, how many drinks per week?
# of drinks _____

Do you use recreational drugs?
- O Yes
- O No

Have you used needles to inject drugs?
- O Yes
- O No

SEXUAL ACTIVITY
Sexual History:
- O Never sexually active
- O Sexually active in the past but not currently
- O Sexually active

If sexually active, partner(s) are:
Male / Female

Birth control method(s):
_____

Have you had a sexually transmitted infection?
- O Yes
- O No

DIET/EXERCISE
Do you drink coffee/tea/soda daily?
- O Yes
- O No

If yes, how many cups per day?
# of cups _____

Do you drink energy drinks?
- O Yes
- O No

If yes, how many per day?
# of energy drinks _____

How many days per week do you exercise for 30 minutes or more?
0 / 1 - 2/ 3 - 4 / 5+

FAMILY HISTORY
Has any family member in the last two generations (siblings, parents, grandparents) had any of the following?
If yes, who and when?

Y	N	Has a family member had?	Who?
O	O	Alcoholism	_____
O	O	Blood clots in legs, lungs	_____
O	O	Cancer	_____
O	O	Depression	_____
O	O	Diabetes	_____
O	O	Genetic disorder	_____

Y	N	Has a family member had?	Who?
O	O	Heart disease	_____
O	O	High blood pressure	_____
O	O	Liver disease	_____
O	O	Stroke, blood vessel disease	_____
O	O	Suicide	_____
O	O	Other: _____	_____

SURGICAL HISTORY
List all prior operations you have had, with dates (i.e. appendectomy, pinning of fracture):

_____
_____
_____

HOSPITALIZATIONS
List any hospitalizations not included in surgical history (i.e. overnight stay):

_____
_____
_____

ADDITIONAL INFORMATION
Is there anything about your physical, mental or emotional health that would be helpful to Student Health Services in providing you medical care?

_____
_____

READ, CHECK AND SIGN BELOW.

- O I am aware that Student Health Services charges for some services that are not covered under the student health fee. I accept personal responsibility for the payment of incurred charges at the time services are rendered.
- O I understand that I am responsible for filing outpatient charges with my health insurance carrier and acknowledge that my responsibility to the University is unaffected by the existence of health insurance coverage.
- O I authorize any medical treatment for myself that may be advised or recommended by the medical providers at Student Health Services.
- O I have personally supplied the above information and attest that it is true and complete to the best of my knowledge. I understand that the information contained on this form and in my medical records is strictly confidential and will not be released to anymore other than my healthcare provider, without my written authorization unless required by law. If I should be ill or injured or otherwise unable to sign the appropriate medical release form, I give my permission to Student Health Services to release information from my medical record to a physician, hospital, or other medical professional involved in providing me with emergency treatment and/or medical care.

_____
Signature of patient Date

_____
Signature of legal guardian (if patient is under 18) Date

_____
Signature of reviewing medical provider Date