

HAWKEYE COMMUNITY COLLEGE
Student Health Clinic
Health History Form

Hawkeye Community College Student Health Clinic requests this confidential information for the purpose of providing patient care. Persons outside the Student Health Clinic are not routinely provided this information without the patient's knowledge and written consent. Responses to all items are required in order to facilitate appropriate patient care.

A. PERSONAL DATA PLEASE PRINT LEGIBLY

Today's Date _____

Last Name _____ First Name _____ DOB _____

Current Address _____

city state zip code

e-mail address

Current phone # _____ Alternate Phone # _____

Cell phone or home phone or msg phone

cell phone or home phone or msg phone

SSN # _____ Ethnicity _____ Male or Female Marital Status Single Married Widowed Separated

Health Insurance Information (need copy of card both front and back) please complete ALL information below

Name of Policy Holder _____ DOB of policy holder _____

Father, Mother, Spouse, Other

Address of policy holder if different than above _____

Street, City, State, Zip Code

Phone # _____ Name of Insurance Company _____

B. PAST MEDICAL HISTORY AND ILLNESSES

Please mark the box if YOU have ever had any of the following? :

- Migraine
- High Blood Pressure
- Heart Problems
- High Cholesterol
- Heart Murmur
- Diabetes
- Asthma
- Thyroid problem
- Orthopedic problem (Arthritis, knee, back etc.)
- Stomach Problems (Ulcer, reflux, IBS)
- Mental Health (ADD/ADHD, Anxiety, Depression, Eating Disorder, Other)
- Alcohol/Drug Problems
- Trauma/Domestic Abuse

Disability -Type _____

Cancer -Type: _____

Surgery -Yr/type: _____

C. FAMILY HISTORY (past or present)

Please mark the box if a parent, sibling, or any of your children have ever had any of the following.

- Migraine
- High Blood Pressure
- Heart problems
- High cholesterol
- Diabetes
- Stroke
- Thyroid problems
- Epilepsy/seizure
- Bleeding Disease
- Arthritis
- Anxiety
- Depression
- Alcohol/drugs
- Obesity
- Cancer- Type: _____

Have you ever had chicken pox? Yes No

Do you take any medications? (including birth control and supplements/vitamins) List all
Do you currently have any illness which you are currently under medical / mental health care? <input type="checkbox"/> Yes <input type="checkbox"/> No
List any allergies to: Medications _____ Foods _____ Other (latex, bee sting, seasonal, etc.) _____

PLEASE COMPLETE REVERSE SIDE



D. Medical / Social History:

What is/will be your living arrangement? (apartment, home, dorm) Who do you live with? (roommate, parent, spouse, alone, other)

Do you feel safe in your environment? Yes No

Have you had a tetanus vaccine in the last 10 years? Yes No

Have you ever received the meningitis vaccine? Yes No

Have you ever received or are you now receiving treatment or counseling for mental health reasons and / or alcohol/drug problems? Yes No

Have you often been bothered by feeling down, depressed or hopeless? Yes No

Have you often been bothered by little interest or pleasure in doing things? Yes No

During the past month, have you been bothered by feeling worried, tense or anxious most of the time? Yes No

In the past 6 months, have you ever had an episode when, for no apparent reason your heart suddenly began to race or you felt faint, or you couldn't catch your breath? Yes No

For Men: When was the last time you had more than five drinks in one day?
 Never In the past three months Over three months ago

For Women: When was the last time you had more than four drinks in one night?
 Never In the past three months Over three months ago

Do you now or have you ever used Tobacco? Yes No If Yes: Avg packs/day _____ # years smoked _____

Year quit _____ When are you planning to quit? Now Next 6 months Sometime Never

FEMALES ONLY

PLEASE MARK BOX IF YOU HAVE EVER HAD ANY OF THE FOLLOWING.

<input type="checkbox"/> Menstrual irregularity	<input type="checkbox"/> Ovarian cysts	<input type="checkbox"/> Pelvic inflammatory disease	<input type="checkbox"/> Vaginitis
<input type="checkbox"/> Abnormal pap smear follow up: (if so, which of the following) <input type="checkbox"/> biopsy <input type="checkbox"/> colposcopy <input type="checkbox"/> tx (cryo, LEEP, laser, cone)		Age at first intercourse _____ Do you ever use laxatives or vomiting to lose weight? <input type="checkbox"/> yes <input type="checkbox"/> no	

What was the date of last pap smear? _____ Where? (name of clinic/ doctor) _____

Are you using birth control? yes no If yes, what type? _____

Are you planning a pregnancy in the next 2 years? yes no

Do you do self breast exams? yes no

MENTRUAL HISTORY

Age at first period: _____ Age at menopause: _____ Periods are: regular/ irregular (circle one) Periods last _____ days
 Menstrual flow is: light/ moderate/ heavy (circle one) Cramps with period: yes/ no (circle one) What meds used for cramps: _____

CONTRACEPTIVE HISTORY

In the past I have used: Birth control pills Depo provera Norplant The patch Foam/condoms Withdrawal
 Natural family planning Tubal ligation Other: _____

PREGNANCY HISTORY

Date Mo/Yr	Birth Wt	Sex M/F	Vaginal C-section	Complications	
					REVIEWED BY STAFF INITIALS AND DATE _____ _____ _____ _____