

Coastal Carolina University • Student Health Services • Health History Form

Last name (print) _____ First _____ Middle _____
 Today's date _____ Social Security number _____
 Home address _____
 City _____ State/Country _____ Zip code _____
 Telephone number (_____) _____ Date of birth _____ Male Female
 Emergency contact: Name _____ Relationship _____
 Address _____
 Emergency contact telephone (_____) _____ Business telephone (_____) _____
 Health insurance _____ Marital status _____ Month/year you are entering CCU _____
(include copy)

Are you ALLERGIC to any of the following?

Yes No MEDICATIONS: If yes, name _____
 Yes No FOOD: If yes, name _____
 Yes No INSECT VENOM: If yes, name _____
 Yes No POLLEN, DUST, MOLD, ANIMALS: If yes, name _____
 Yes No OTHER _____

FAMILY HISTORY

	Age	State of Health	Occupation	Age of Death	Cause of Death
Father	_____	_____	_____	_____	_____
Mother	_____	_____	_____	_____	_____
Brothers	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
Sisters	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

FAMILY HISTORY

	Yes	No	Relationship
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Depression/Drug/Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____

HAVE YOU HAD	YES	NO	HAVE YOU HAD	YES	NO	HAVE YOU HAD	YES	NO	HAVE YOU HAD	YES	NO
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Eating Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Back Problems	<input type="checkbox"/>	<input type="checkbox"/>	Bone Disease	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Head Injury	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness/Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Ear problems	<input type="checkbox"/>	<input type="checkbox"/>	Eye problems	<input type="checkbox"/>	<input type="checkbox"/>	Measles	<input type="checkbox"/>	<input type="checkbox"/>
Gall Bladder Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	Rupture, Hernia	<input type="checkbox"/>	<input type="checkbox"/>
Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Insomnia	<input type="checkbox"/>	<input type="checkbox"/>	Mumps	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>
Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Surgery	<input type="checkbox"/>	<input type="checkbox"/>	OTHER	_____	_____
Rubella	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Troubles	<input type="checkbox"/>	<input type="checkbox"/>	Appendectomy	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Weight Changes	<input type="checkbox"/>	<input type="checkbox"/>	STDs	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillectomy	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
MALES ONLY			FEMALES ONLY			Hernia Repair	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Testicular Mass	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual problem	<input type="checkbox"/>	<input type="checkbox"/>	ADHD	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Prostate Infection	<input type="checkbox"/>	<input type="checkbox"/>	Endometriosis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____

PRESENT MEDICATIONS: *(Please include birth control, vitamins and herbal supplements.)*

Drug	Dose	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you smoke? No Yes If yes, how much _____
 Do you use alcohol? No Yes If yes, how much _____
 Do you exercise? No Yes If yes, how often/type _____

The above information is true to the best of my ability. I consent to medical treatment at Coastal Carolina University's Student Health Services.

Student signature _____ Date _____
(Parent signature required if student is younger than 18 years old.)

