Coastal Carolina University • Student Health Services • Health History Form

Last name (print) ______________________ First ______________ Middle ____________

Social Security number ____

Permanent address ____

City ______________________ State/Country ____________ Zip code ____________

Telephone number (_____) ____________ Date of birth ______________ ☐ Male ☐ Female

Emergency contact: Name ______________________________ Relationship ____________

Address ____

Emergency contact telephone (_____) ____________ Business telephone (_____) ____________

Marital status ______________________ Month/year you are entering the University____________

Health insurance company name ______________________ Telephone (_____) ____________

Policy holder's name ______________________ Policy number ____________

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					

	Yes	No	Relationship
Tuberculosis	☐	☐	
Diabetes	☐	☐	
Kidney Disease	☐	☐	
Heart Disease	☐	☐	
Thyroid Problems	☐	☐	
Cancer	☐	☐	
Asthma	☐	☐	
Depression/Drug/Alcohol	☐	☐	
Seizures	☐	☐	

HAVE YOU HAD	YES	NO
Anemia	☐	☐
Back Problems	☐	☐
Gall Bladder Trouble	☐	☐
Jaundice	☐	☐
Palpitations	☐	☐
Rheumatic Fever	☐	☐
Rubella	☐	☐
Weight Changes	☐	☐
Eating Disorders	☐	☐
Anxiety/Depression	☐	☐
ADHD / ADD	☐	☐

HAVE YOU HAD	YES	NO
Headaches	☐	☐
Insomnia	☐	☐
Chest Pains	☐	☐
Heart Murmurs	☐	☐
Stomach Troubles	☐	☐
STIs	☐	☐
Asthma	☐	☐
Cancer	☐	☐
Hypertension	☐	☐
Mumps	☐	☐
Recurrent Diarrhea	☐	☐

HAVE YOU HAD	YES	NO
Surgery	☐	☐
Appendectomy	☐	☐
Tonsillectomy	☐	☐
Hernia Repair	☐	☐
Other surgery (specify):		
Diabetes	☐	☐
Head Injury	☐	☐
Rupture, Hernia	☐	☐

HAVE YOU HAD	YES	NO
Scarlet Fever	☐	☐
Tuberculosis	☐	☐
MALES ONLY		
Testicular Mass	☐	☐
Prostate Infection	☐	☐
FEMALES ONLY		
Menstrual problem	☐	☐
Endometriosis	☐	☐
OTHER____________		

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. Payment for any incurred charges will be the responsibility of the student.

Student signature ______________________________ Date ____________

(Parent/Legal guardian signature required if student is under the age of 18.)