TEXAS TECH UNIVERSITY
Student Health Services

Study Abroad Health History

Student Health Services requires a completed Health History on all patients. This information is confidential and used as an aid in providing necessary healthcare while you are a student. This information will only be shared with your permission.

Name: _____
Last First Middle Initial

Gender: _____M _____F *Date of Birth*: _____/_____/_____ *Student ID* R: _____

Local Address: _____
Street Apt. City/State/Zip

Phone #:(_____)_____ *Marital Status*: _____ Married _____ Single

Permanent Address:_____
Street Apt. City/State/Zip

Ethnicity: American Indian _____ Asian _____ Black_____ Hispanic _____ White _____ Other_____

Language Preference: English _____ Other _____

EMERGENCY CONTACT

Name: _____ *Relationship*: Mother _____ Father _____ Other _____

Address: _____ *Phone #*:(____)_____
Street Apt. City/State/Zip

PERSONAL HEALTH HISTORY

Exercise: No ____ Yes ____ Times per week: _____ Height: _____ Weight: _____
Tobacco Use: Never _____ Previous _____ Current _____ Cigarettes/Dip/Chew/Other Amount: _____
Drug Use (social): Never ____ Previous ____ Current _____ Drugs Used: _____

Please circle one answer for each question	**0**	**1**	**2**	**3**	**4**	**Subtotal**
How often did you have a drink containing alcohol in the past year?	never	Monthly or less	2-4 x a month	2-3 x a week	4+ x a week	
How many drinks containing alcohol did you have on a typical day when you were drinking in the past year	1 or 2	3 or 4	5 or 6	7 or 9	10+	
How often did you have six (6) or more drinks on one occasion in the past year?	Never	Less than monthly	Monthly	Weekly	Daily or almost Daily	
We will calculate the totals					**Total**	

Have you been hospitalized? If yes, please list dates and give a brief explanation: _____
_____
Have you had surgery or a serious injury? If yes, please list surgeries and/or injuries with dates: _____
_____
Do you take any over-the-counter or prescription medications regularly? If yes, please list with dosage: _____
_____
Do you have any allergies to medications? If yes, please list and describe the reaction: _____
_____

FOR WOMEN ONLY

Are you or could you possibly be pregnant? Yes:___ No:____ What Contraception or cycle regulation methods do you use? (mark **All** that Apply)
Condoms:__ Depo-Provera:__ Diaphragm:__ Implanon:__IUD:__ Nuva Ring:__ Pills:___
Other:_____

I HERBY CERTIFY THAT THE ABOVE HISTORY IS COMPLETE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

_____ _____
Student Signature Date