TEXAS TECH UNIVERSITY
Student Health Services

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: _____ Gender: M F
Last First Middle

Date of Birth: ____/____/_____ Student ID R: _____ Marital Status: _____

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

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

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

Language Preference: English _____ Other _____

Preferred Method of Learning: Verbal _____ Handout _____ Audio/Video_____ Other _____

EMERGENCY CONTACT

Name: _____ Relationship: Mother _____ Father _____ Other _____

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

FAMILY HISTORY (Does your father, mother, sister, brother, maternal/paternal grandparent have/had any of the following)

	Yes	No	Relationship		Yes	No	Relationship
Tuberculosis				**Stroke**			
Epilepsy/Seizures				**Diabetes**			
Heart Disease				**Cancer**			
High Cholesterol				**Ulcers**			
High Blood Pressure				**Other**			
Abnormal Bleeding Tendency							

PERSONAL HEALTH HISTORY

Exercise: No ____ Yes ____ Times per week: _____ Height: _____ Weight: _____

Tobacco Use: Never _____ Previous _____ Current _____ Cigarettes/Dip/Chew/Other Amount: _____

Alcohol Use: Never _____ Previous _____ Current _____ Drinks per Occasion: _____ Times per Week: _____

Drug Use (social): Never ____ Previous ____ Current _____ Drugs Used: _____

History of Sexual Activity: Never _____ Previous/Current _____ If yes, was your partner: Male ___ Female ___ Both ___

Have you ever had any of the following conditions?

	Yes	No		Yes	No		Yes	No
Malaria			**Indigestion or Ulcer**			**Asthma**		
Infectious Mononucleosis			**Abnormal Bleeding Tendency**			**Arthritis**		
Urinary Tract Infection			**Colitis or Colon Problems**			**Chronic Back Problem**		
Kidney Disease			**Gall Bladder or Liver Disease**			**Diabetes**		
High Blood Pressure			**Hay Fever or Allergies**			**Thyroid Disease**		
Heart Disease or Murmur			**Chronic Cough or Pneumonia**			**Under/Over Weight**		
Hepatitis			**Unusual Childhood Illnesses**			**Anorexia/Bulimia**		
Sickle Cell Trait/ Disease			**Tuberculosis**			**Worry/Anxiety**		
Anemia			**Epilepsy/Seizures**			**Dizziness or Fainting Spells**		
Cancer			**Recurrent Headaches**			**Depression**		
Severe Visual Problems			**Chronic Skin Problems**					

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: _____

_____

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

_____ _____
Student Signature Date

The Texas Public Information Act, with a few exceptions, gives you the right to be informed about the information that Texas Tech University collects about you. It also gives you the right to request a copy of that information and to have the University revise any information that is incorrect. You may request to receive this information by contacting the office possessing such information.