HAMLINE UNIVERSITY—COUNSELING & HEALTH SERVICES

HEALTH HISTORY

Updated

The information on this form is confidential and will not be shared with any person or office outside of Hamline University's Counseling & Health Services without your written consent, except under the conditions described below. Counseling and Health Services staff may consult with one another about your care. A copy of our privacy policy is available in our office upon request.

Exceptions to the Policy of Confidentiality: Your information may be shared for purposes of referral or treatment with other care providers such as physicians, nurses and therapists; for health oversight activities authorized by law; to public health authorities with information on communicable diseases and vital records; to law enforcement when required by law, including mandatory abuse reporting; and to appropriate individuals when we believe it necessary to avoid a serious threat to health or safety, or to prevent serious harm to an individual.

I have read and understand the above policy.

______________________________ Student Signature

______________________________ Today's Date

______________________________ Student Name (Print)

______________________________ Student ID Number

Family History

	Age	If Deceased, Age at Death	Cause of Death	Have any of your biological relatives (mother, father, grandmother, grandfather, sister, brother) ever had any of the following?	Yes	No	Relationship
Father				Arthritis			
Mother				Asthma, Hay Fever			
Siblings				Cancer			
				Chemical Dependency (incl. alcoholism)			
				Diabetes			
				Epilepsy, convulsions			
				Heart Disease			
				Mental Illness			

Personal History

Have you ever experienced any of the following? Please check box and comment on "Yes" answers below.

Illness/Symptom	Yes	Illness/Symptom	Yes	Illness/Symptom	Yes
Alcohol Abuse		Eye Disorder		Muscle/Bone Problems	
Anxiety Disorder		Eating Changes (recent)		Palpitations	
Arthritis		Weight Gain		Pneumonia	
Asthma		Weight Loss		Pregnancy	
Back Problems		Gall Bladder Disorder		Recurrent Diarrhea/Constipation	
Blood Disorders		Gum/Dental Disease		Rheumatic Fever	
Blood Pressure, High or Low		Headache (Recurrent)		Scarlet Fever	
Chest Pain Pressure		Head Injury		Seasonal Allergies	
Chicken Pox		Heart Disease		Seizures	
Chronic Cough		Hepatitis		Sexually Transmitted Infections	
Depression		HIV Infection		Substance Abuse	
Diabetes		Kidney Disorder		Sleep Disorder	
Dysmenorrheal, Cramps		Malaria		Stomach Disorder	
Excessive Flow		Measles, Mumps, Rubella		Surgery (Type/Date)	
Irregular Flow		Mental Illness		Tobacco Use	
Dizziness/Fainting		Mononucleosis		Tumor/Cancer/Cyst	
Ear, Nose or Throat Problems		Mood Swings		Tuberculosis	

Please comment on any "Yes" responses.

Hospitalizations

Medications

List all medications taken regularly (Prescription or non-prescription)	List any allergies to medications

Have you had any other illness or injury other than already notes? If so, please list:

I hereby certify, to the best of my knowledge, that the preceding information is complete and correct.

Signature ______________________ Date ______________________

Updated 09/09