UNIVERSITY OF MARYLAND
UNIVERSITY HEALTH CENTER

HEALTH HISTORY FORM

Name: _____ University ID #: _____ Date: _____

Gender: □ Male □ Female □ Transgender (MTF) □ Transgender (FTM) □ Other: _____

Phone #: _____ Marital Status: _____ Date of Birth: _____ Age: _____

Local Address: _____

Drug allergies (list name and reaction): _____

Medications (prescription, over-the-counter): _____

PERSONAL HISTORY

Please explain in the space provided if you answered "yes".

Yes	No	Unsure		Yes	No	Unsure	
□	□	□	Headaches/Migraines/Epilepsy/Seizures _____	□	□	□	Skin/Hair Problems (Acne, Rashes, etc.) _____
□	□	□	Lung Disease (Asthma, Tuberculosis, etc.) _____	□	□	□	Cancer (list type) _____
□	□	□	Heart Disease (High Blood Pressure, Murmurs, etc.) _____	□	□	□	Birth Defects/Disabilities _____
□	□	□	High Cholesterol _____	□	□	□	Mental/Behavioral (Depression, Anxiety, ADHD, etc.) _____
□	□	□	Stroke/Blood Clots _____	□	□	□	Other Illnesses/Injuries _____
□	□	□	Stomach or Intestinal Problems (Reflux, Crohn's disease, Gluten/Lactose intolerance, Irritable bowel, etc.) _____	□	□	□	Surgery (Tonsils, Wisdom Teeth, Appendix, etc.) _____
□	□	□	Liver Disease (Mononucleosis, Hepatitis, Jaundice, etc) _____	□	□	□	Hospitalization (admitted overnight) _____
□	□	□	Gallbladder Disease _____	□	□	□	Are you concerned about your weight/eating habits? _____
□	□	□	Urinary Problems (Infections, Kidney Stones, etc.) _____	□	□	□	Do you participate in a regular exercise program? _____
□	□	□	Joint, Muscle or Bone (Scoliosis, Fractures, etc.) _____	□	□	□	Do you smoke cigarettes? How much per day? _____
□	□	□	Blood Problems (Anemia, Clotting, Sickle Cell, etc.) _____	□	□	□	Do you drink alcohol? How much per week? _____
□	□	□	Endocrine Problems (Diabetes, Thyroid, PCOS, etc.) _____	□	□	□	Have you ever used or taken any illegal drugs or medications that were NOT prescribed for you? (Marijuana, Cocaine, Heroin, LSD, Shrooms, Ecstasy, Adderall, Oxycontin, Other?) _____

FAMILY HISTORY

□ Adopted

Please list which family members (father, mother, siblings, grandparents, etc.) in the space provided if you answered "yes".

Yes	No	Unsure		Yes	No	Unsure	
□	□	□	Lung Disease (Asthma, Tuberculosis, etc.) _____	□	□	□	Stroke _____
□	□	□	High Blood Pressure _____	□	□	□	Blood Clots _____
□	□	□	Heart Attack BEFORE age 50 _____	□	□	□	Breast Cancer _____
□	□	□	Other Heart Disease _____	□	□	□	Other Cancer(s) _____
□	□	□	High Cholesterol _____	□	□	□	Birth Defects/Genetic Traits _____
□	□	□	Diabetes _____	□	□	□	Mental Illness _____
□	□	□	Thyroid Disease _____	□	□	□	Other Significant Family History _____

PLEASE COMPLETE THE REVERSE SIDE

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SEXUAL HEALTH HISTORY

Have you had intercourse? □ Yes □ No
Age at first intercourse: _____
Number of partners in the last 12 months: _____ Number of lifetime partners: _____
Partner(s): □ Male □ Female □ Both
Do you use condoms or other STD/STI prevention methods? □ Always □ Sometimes □ Never
Have you or your partner ever used birth control? □ Yes □ No
If "yes", what type(s) of birth control(s) have you used in the past? _____
Have you had any history of the following STDs/STIs?: □ Yes (please circle below) □ No □ Unsure
Gonorrhea, Chlamydia, Genital Herpes, Genital Warts, HIV, Trichomonas, Hepatitis B, Hepatitis C, HPV, Other: _____
Do you have any questions/concerns about your sexual health? _____

Are there any areas of health or well-being you would like to discuss? _____

The information provided is accurate to the best of my knowledge.

SIGNATURE: _____ DATE: _____

FEMALE PATIENTS ONLY

MENSTRUAL HISTORY

Age menstrual periods began: _____
Menstrual periods come every _____ days
Number of days of menstrual flow _____
Consistency of menstrual flow □ Light □ Moderate □ Heavy
Do you think you might be pregnant now? □ Yes □ No □ Maybe
Have you ever:

□ Yes □ No Had missed periods?
□ Yes □ No Had bleeding in between periods?
□ Yes □ No Had pain with periods (menstrual cramps)?
□ Yes □ No Taken medications for pain? If "yes", which medications? _____
□ Yes □ No Had other premenstrual symptoms? If "yes" which symptoms? _____

GYNECOLOGICAL HISTORY

Have you ever:

□ Yes □ No Had a pelvic exam? If "yes", what is the date of your last exam? _____
□ Yes □ No Had any vaginal infections (yeast, bacterial vaginosis, etc.)? _____
□ Yes □ No Had any pelvic infections (uterus, fallopian tubes, ovaries, or PID)? _____
□ Yes □ No Had other problems with your uterus, fallopian tubes or ovaries (fibroids, tubal pregnancy)? _____
□ Yes □ No Had pain or bleeding with intercourse? _____
□ Yes □ No Had abnormal pap smear(s)? If "yes", what are the dates? _____

PREGNANCY HISTORY

Have you ever been pregnant? □ Yes □ No
Age at first pregnancy _____
Number of pregnancies _____
Number of live births _____ (Number of full term births > 37 weeks _____ Number of premature births < 37 weeks _____)
Number of miscarriages _____ Number of abortions _____
Number of living children _____

OFFICE USE ONLY

Reviewed by: _____