

SECTION II – HEALTH HISTORY

Please complete this section so the Student Health Service can be aware of any specific health issues that may affect you while a student at the University of Wyoming. Section II can be completed at the time of your first visit to the Student Health Service. Use an additional sheet to complete answers if necessary. All information is confidential.

1. Have you ever been hospitalized? _____ Yes _____ No
If yes, please give details and dates _____

2. Have you ever had surgery? _____ Yes _____ No
If yes, please give details and dates _____

3. Do you take any medication (prescription, nonprescription, herbal, etc.) on a regular basis? _____ Yes _____ No
If yes, please list medication and dosage _____

4. Do you have any allergies to medication, food, environment, or other substances? _____ Yes _____ No
If yes, please list allergies and reaction _____

5. Do you smoke or chew tobacco? _____ Yes _____ No
If yes, age began _____
How many cigarettes do you smoke each day? _____ How many cans of tobacco do you use each week? _____

6. Have you had or do you now have any of the following? If yes, note date of occurrence, if known.

	No	Yes (Date)		No	Yes (Date)
Head/Neurological			Gastrointestinal		
Frequent headaches	<input type="checkbox"/>	_____	Abdominal pain	<input type="checkbox"/>	_____
Migraine headaches	<input type="checkbox"/>	_____	Ulcer	<input type="checkbox"/>	_____
Dizziness or fainting	<input type="checkbox"/>	_____	Blood in stool	<input type="checkbox"/>	_____
Loss of consciousness	<input type="checkbox"/>	_____	Hepatitis	<input type="checkbox"/>	_____
Head injury	<input type="checkbox"/>	_____	Hernia	<input type="checkbox"/>	_____
Seizures/epilepsy	<input type="checkbox"/>	_____	Irritable bowel syndrome	<input type="checkbox"/>	_____
Eyes			Inflammatory bowel disease	<input type="checkbox"/>	_____
Vision or eye problems	<input type="checkbox"/>	_____	Musculoskeletal		
Wear glasses/contact lens	<input type="checkbox"/>	_____	Swollen/painful joints	<input type="checkbox"/>	_____
Ears/Nose/Throat			Recurrent low back pain	<input type="checkbox"/>	_____
Allergies/hay fever	<input type="checkbox"/>	_____	Arthritis	<input type="checkbox"/>	_____
Ear or hearing problems	<input type="checkbox"/>	_____	Endocrine		
Frequent sinusitis	<input type="checkbox"/>	_____	Diabetes mellitus	<input type="checkbox"/>	_____
Dental problems or TMJ	<input type="checkbox"/>	_____	Thyroid problem	<input type="checkbox"/>	_____
Skin			Genitourinary		
Acne or other skin disorder	<input type="checkbox"/>	_____	Urinary tract infections	<input type="checkbox"/>	_____
New or changing moles	<input type="checkbox"/>	_____	Kidney stones	<input type="checkbox"/>	_____
Blood disorder			Menstrual disorder	<input type="checkbox"/>	_____
Anemia	<input type="checkbox"/>	_____	Psychological disorders		
Bleeding disorder	<input type="checkbox"/>	_____	Eating disorder	<input type="checkbox"/>	_____
Enlargement of glands or lymph nodes	<input type="checkbox"/>	_____	Depression	<input type="checkbox"/>	_____
Sickle cell disease	<input type="checkbox"/>	_____	Anxiety	<input type="checkbox"/>	_____
Heart/Chest			Additional Medical Conditions		
Heart murmur	<input type="checkbox"/>	_____	Cancer	<input type="checkbox"/>	_____
Rapid or irregular pulse	<input type="checkbox"/>	_____	Unusual fatigue	<input type="checkbox"/>	_____
Blood clot	<input type="checkbox"/>	_____	Recent gain or loss (>10 lbs) of weight	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	_____	Insomnia	<input type="checkbox"/>	_____
Elevated cholesterol	<input type="checkbox"/>	_____	Mononucleosis	<input type="checkbox"/>	_____
Respiratory			Other illnesses not listed		
Asthma	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	_____
Pneumonia	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	_____
Positive PPD or Tuberculosis	<input type="checkbox"/>	_____			
Chronic cough (>1 month)	<input type="checkbox"/>	_____			

If yes to any of the above conditions, please give details _____

Signature of student _____

Date _____

THANK YOU FOR COMPLETING THIS FORM