Florida Gulf Coast University
Student Health Services
HEALTH HISTORY FORM

Phone: 239-590-7966
Fax: 239-590-7575

Name: _____

Student ID#: _____

Date: _____

Date of Birth: _____/____/_____ Age: _____

Cell Phone Number: _____

Do You Have Health Insurance? Circle One:
Yes No I Don't Know

FAMILY HISTORY – Check any that apply to family member(s). ☐ None Known

☐ I am adopted	☐ Cancer	☐ Kidney Disease	☐ Sickle Cell	☐ Other
☐ Alcoholism	☐ Convulsions	☐ Liver Disease	☐ Stroke	_____
☐ Alzheimer's/Dementia	☐ Diabetes	☐ Mental Illness	☐ Sudden Death	_____
☐ Arthritis	☐ Heart Disease	☐ Migraine Headaches	☐ Thyroid Disease	
☐ Asthma	☐ High Blood Pressure	☐ Ovarian Cancer		
☐ Blood Disorders/Clots	☐ High Cholesterol	☐ Polycycstic Ovarian Syndrome		

YOUR PERSONAL MEDICAL HISTORY – Check any for which you have been diagnosed or treated.

☐ ADHD/ADD	☐ Bladder/Kidney Infection	☐ Diabetes	☐ Headache	☐ Obesity	☐ Other	
☐ AIDS/HIV	☐ Cancer	☐ Eating Disorder	☐ Heart Disease	☐ Rheumatoid Disease	_____	
☐ Alcoholism	☐ Cardiac Abnormalities	☐ Emotional	☐ High Blood Pressure	☐ Seasonal Allergies	_____	
☐ Anemia	☐ Congenital Abnormality	☐ Fainting/Dizziness	☐ Insomnia	☐ Sickle Cell	_____	
☐ Anxiety	☐ Constipation	☐ Frequent Colds	☐ Kidney Disease	☐ Thyroid Disease		
☐ Asthma	☐ Depression	☐ Gastrointestinal	☐ Migraine Headache	☐ Tuberculosis		

What **surgeries** have you had? ☐None
List: _____

What **Medications** do you take? ☐None
(Include Birth control, Vitamins, Supplements etc.)
List: _____

Allergies? ☐None
List: _____

HABITS

Do you Smoke? Yes☐ No☐ Amount_____
Do you Drink? Yes☐ No☐ Amount_____
Do you Exercise? Yes☐ No☐ Amount_____

SEXUAL HISTORY SECTION

Have you ever had sexual intercourse? Yes☐ No☐

Which contraceptive do you use? Abstinence ☐ None ☐ Condoms ☐ Pill ☐ Ring ☐ Depo ☐ Patch ☐ IUD ☐ Implant ☐ Surgical ☐

Have you ever been diagnosed or treated for a sexually transmitted infection? Yes☐ No☐

Have you had the HPV Vaccine (Gardasil or Cervarix)? Yes, all 3 doses ☐ 2 of 3 doses ☐ 1 dose ☐ None ☐

Has there been *past* or *current* domestic violence or sexual abuse? Yes☐ No☐

The remainder of this form is to be completed by women only

WOMEN'S HEALTH HISTORY SECTION

Menstrual History: Age of onset of Period?_____Years old. Are your periods Regular (21-38 days apart) ☐ or Irregular? ☐

When was the First day of your Last menstrual Period?_____-_____-_____

How many days do you typically bleed?_____days.

Have ever you ever had a pelvic examination? Yes☐ No☐

Have you ever had **Ovarian Cysts** Yes☐ No☐ **Endometriosis** Yes☐ No☐

Pain/bleeding with sex Yes☐ No☐ Other - Describe_____

Have you ever had an abnormal pap smear? Yes☐ No☐

Date of last pap smear_____-_____-_____

Have you ever been pregnant? Yes☐ No☐ If yes, number of pregnancies_____Number of live births _____