ENTRANCE FORM: Personal Health History, Family Health History, Medications, Allergies

MyUHS

PERSONAL HEALTH HISTORY

Please check all conditions that you currently have or have had in the past. Exact date of onset is not necessary, you can enter the approximate age or "unsure" if you do not know.

Health History

- -No history of significant health problem
- Allergies (seasonal or year-round)
- Anemia or other blood disorder
- Asthma
- Autoimmune disorder
- Blood clots
- Cancer
- Cancer (Breast)
- Cancer (Colon)
- Cancer (Ovarian)
- Cancer (Skin)
- Cholesterol or lipid abnormalities
- Diabetes (type I)
- Diabetes, adult onset (type II)
- Digestive disorders
- Eating disorder
- Endometriosis
- Head injury
- Heart/cardiovascular disorder
- High blood pressure/hypertension
- Joint or rhematologic problems
- Kidney disease
- Menstrual disorder
- Migraine or other severe headaches
- Polycystic ovarian syndrome
- Pregnancy or childbirth
- Seizure disorder
- Significant injury
- Skin disorder
- Sleep disorder
- Thyroid disorder
- Tuberculosis, active disease
- Tuberculosis, inactive/positive TB skin test

Mental Health History

- Anxiety disorder
- Attention deficit disorder
- Bipolar disorder
- Depressive disorder
- Mental health problem (other)
- Psychotic disorder (e.g.: schizophrenia)

Substance Use History

- Alcohol abuse or dependency
- Drug (other than alcohol) abuse or dependency
- Tobacco use (current)
- Tobacco use (past)

Unlisted/Other Health Problem

- Deceased immediate family member
- No personal health problem
- Other personal health problem (see comment)

Comment

SURGERIES AND HOSPITALIZATIONS

Please list all surgeries you have had and any over night hospitalizations. Exact date is not necessary, you can enter the approximate age or "unsure" if you do not know.

#	Description	Approx Date	
1			delete

add more

FAMILY HEALTH HISTORY

Please check any condition present in your family prior to age 80 (parents, siblings, grandparents only). Exact date of onset is not necessary, you can enter the approximate age or "unsure" if you do not know.

Health History

- -No significant family health problems
- Adopted and family health history unknown
- Autoimmune disorder
- Blood clots
- Cancer

Mental Health History

- Anxiety disorder
- Attention deficit disorder
- Bipolar disorder
- Depressive disorder
- Mental health problem (other)
- Psychotic disorder (e.g.: schizophrenia)

Substance Use History

- Alcohol abuse or dependency
- Drug (other than alcohol) abuse or dependency

Unlisted/Other Health Problem

☐ Cancer (Breast) ☐ Cancer (Colon) ☐ Cancer (Ovarian) ☐ Cancer (Skin) ☐ Cholesterol or lipid abnormalities ☐ Diabetes (type I) ☐ Diabetes, adult onset (type II) ☐ Eating disorder ☐ Endometriosis ☐ Genetic disorder ☐ Heart disease/cardiovascular disorder ☐ Heart/cardiovascular disorder ☐ High blood pressure/hypertension ☐ Joint or rhematologic problems ☐ Kidney disease ☐ Migraine or other severe headaches ☐ Polycystic ovarian syndrome ☐ Sleep disorder	☐ Suicide	☐ No known family health problems ☐ Other family health problem (see comment)

Comment

ALLERGIES AND MEDICATIONS

ALLERGIES: Please list all medication(s) and food(s) you are allergic to. Enter "none" if you do not have any allergies.

#	Name of Substance	Type of Reaction	Approx Date of Onset	
1				delete

add more

MEDICATIONS: Please list all medications you are currently taking on a daily or as needed basis. Enter "none" if not taking any medications.

#	Name of Medication	Dosage of Medication	
1			delete

add more

Submit Final **Click here to submit the final content of the form**
(You cannot change items after the form has been submitted.)

Save Partial **Click here to save the intermediate content of the form**
(Currently entered values will be recorded and you will be able to resume completing the form at a later time.)

Cancel **Click here to cancel entering the form**
(Currently entered changes will not be saved.)