



Health History Questionnaire

Identification	
College PRN Number	
Name (last, first, middle)	Registration Data
Address (home) Zip	Expected year of graduation: 20 Undergraduate Student
City State Zip	Graduate Student Summer Program
Address (Local) Zip	Exchange Student
City State Zip	School/College
Cell Phone Home Phone	College of Arts and ScienceCollege of Health Professions
Birth date : / / Y	College of PharmacyCollege of Osteopathic Medicine
Sex:Female Male	College of Dental Medicine
Ethnicity :White/Non Hispanic American Indian	College of Dental HygieneInternational Program
Black or Alaskan Native	Entering Term and Year
Hispanic Other Asian /Pacific Islander	FallSpringSum Year
Parent/Partner Name:	Have you ever been a matriculated student at
Last First	University of New England? Yes/ No
Home/Cell Phone	If yes, last year attended
Parent/Partner Name:	Have you ever been a patient at University of
Last First	New England Health Centers? Yes/ No
Home/Cell Phone	-
Person to notify in case of an Emergency	
Name (last, first)	
Address	
City State Zip	
Home Cell	



Student Health Services

Health History Questionnaire

Name:		DOB:
Have you had any of the fall	owing conditions? Places show	ok avalain and for data if needed
		ck, explain and /or data if needed
Ears, Ears, Nose & Throat:	Skeletal:	Allergies:
Dry eyes	Arthritis	Please list your allergies:
Conjunctivitis	Back problems	Meds, Food, Environmental
Hearing loss	Serious disability	
Ear infections	Broken bones	
Sinus issues	Location	
Strep throat	Chronic Bone disease	
Tonsillitis	Joint problems	
Tonsillectomy	Muscle problems	
Contacts	Other	
Glasses		
Other		
Skin:	Mental Health:	Medications and Dosing:
Rashes	Anxiety	Include Birth Control, Vitamins,
Herpes	Depression	Herbal Therapy
Psoriasis	Bulimia	Tierbui Tierupy
Eczema	Anorexia	
	Cutting	
Skin Cancer	Cutting	
PiercingLocation	Suicidal History	
Tattoos Location		
Other		
Respiratory:	Neurology:	Surgical History:
Asthma	Seizures	Have you had any surgeries in
Pneumonia	Epilepsy	your life time?
Tuberculosis	Narcolepsy	List what type and the year it
Bleeding disorder	Fainting	was done.
Anemia	ADD/ADHD	was done.
Other	Autism	
Other		
	Aspergers	
	Dyslexia	
	Tourettes	
	Learning Disability	
	Headaches	
	Migraines	
	Sleep Disorder	
	Other	
Cardio:	Endocrine:	Do you or your blood relatives
Heart Murmur	Thyroid disease	have any of the following
High Blood Pressure	Diabetes	conditions?
Palpitations	PCOS	Alcoholism
High Cholesterol		Arthritis
Rheumatic fever		Chronic Back Problems
Other		Heart disease
		Cancer
Gastroenterology:	Social History:	Celiac
Stomach problems	Alcohol abuse	Chron's disease
Ulcers	How much do you	COPD
Celiac disease	drink?how often	Colitis
Chronic Heartburn	Tobaccopks per day	Cystic fibrosis
Hepatitis	How long	Depression
	Dip	Diabetes
	· 	Drug dependency
		Hypertension
		Hyperlipidemia
		MS
		Pulmonary emboli
		PVD
		Rheumatoid arthritis
		Other