UNIVERSITY OF NEW ENGLAND

Student Health Services

Health History Questionnaire

Identification

____
College PRN Number

____
Name (last, first, middle)

____
Address (home) Zip

____
City State Zip

____
Address (Local) Zip

____
City State Zip

____
Cell Phone Home Phone

Birth date : ___ _/____/ _____
M D Y

Sex: ___Female _____ Male

Ethnicity: _____White/Non Hispanic ___ American Indian
_____Black or Alaskan Native
_____Hispanic ___ Other
_____ Asian /Pacific Islander ____________________

Parent/Partner Name:

____
Last First

____
Home/Cell Phone

Parent/Partner Name:

____
Last First

____
Home/Cell Phone

Person to notify in case of an Emergency

____
Name (last, first)

____
Address

____
City State Zip

____
Home Cell

Registration Data

Expected year of graduation: 20_____
_____Undergraduate Student
_____ Graduate Student
_____ Summer Program
_____ Exchange Student

School/College

____College of Arts and Science
____College of Health Professions
____College of Pharmacy
____College of Osteopathic Medicine
____College of Dental Medicine
____College of Dental Hygiene
____International Program

Entering Term and Year

____ Fall ____Spring ____Sum____ Year____

Have you ever been a matriculated student at

University of New England? **Yes/ No**

If yes, last year attended__________________

Have you ever been a patient at University of New England Health Centers? **Yes/ No**

Revised 6/13/13, 12/12/13

UNIVERSITY OF NEW ENGLAND

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Health History Questionnaire

Name: ____ **DOB:** ____________________

Have you had any of the following conditions? Please check, explain and /or data if needed

Ears, Ears, Nose & Throat: Dry eyes _______ Conjunctivitis_______ Hearing loss_______ Ear infections_______ Sinus issues_______ Strep throat_______ Tonsillitis_______ Tonsillectomy_______ Contacts________ Glasses_______ Other_______	**Skeletal:** Arthritis______ Back problems______ Serious disability_______ Broken bones_______ Location_______ Chronic Bone disease______ Joint problems_______ Muscle problems______ Other_______	**Allergies:** Please list your allergies: Meds, Food, Environmental __________________________ __________________________ __________________________
Skin: Rashes_______ Herpes_______ Psoriasis_______ Eczema_______ Skin Cancer_______ Piercing ______Location_______ Tattoos ______ Location_______ Other________	**Mental Health:** Anxiety_______ Depression_______ Bulimia_______ Anorexia_______ Cutting_______ Suicidal History______	**Medications and Dosing:** Include Birth Control, Vitamins, Herbal Therapy __________________________ __________________________ __________________________
Respiratory: Asthma_______ Pneumonia_______ Tuberculosis_______ Bleeding disorder______ Anemia_______ Other________	**Neurology:** Seizures_______ Epilepsy_______ Narcolepsy_______ Fainting_______ ADD/ADHD_______ Autism_______ Aspergers______ Dyslexia_______ Tourettes_______ Learning Disability_______ Headaches________ Migraines_______ Sleep Disorder________ Other________	**Surgical History:** Have you had any surgeries in your life time? _______ List what type and the year it was done. __________________________ __________________________ __________________________
Cardio: Heart Murmur_______ High Blood Pressure_______ Palpitations_______ High Cholesterol_______ Rheumatic fever_______ Other_______	**Endocrine:** Thyroid disease_______ Diabetes_______ PCOS_______	**Do you or your blood relatives have any of the following conditions?** Alcoholism_______ Arthritis _______ Chronic Back Problems_____ Heart disease_______ Cancer_______ Celiac_______ Chron's disease_______ COPD_______ Colitis_______ Cystic fibrosis_______ Depression_______ Diabetes _______ Drug dependency_______ Hypertension_______ Hyperlipidemia_______ MS_______ Pulmonary emboli_______ PVD_______ Rheumatoid arthritis______ Other________________
Gastroenterology: Stomach problems_____ Ulcers_______ Celiac disease_____ Chronic Heartburn_______ Hepatitis_______	**Social History:** Alcohol abuse_______ How much do you drink?____how often____ Tobacco____pks per day___ How long _______ Dip_____	