

# UNIVERSITY OF WISCONSIN-GREEN BAY STUDENT HEALTH HISTORY FORM

UW-Green Bay Campus ID #:	Soc Sec Number / /	Date of Birth / /	Male <input type="checkbox"/> Female <input type="checkbox"/>
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NAME (Last, First, Middle): \_\_\_\_\_

LOCAL OR CAMPUS ADDRESS (No., Street, City, State, Zip): \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

IN EMERGENCY, NOTIFY: Name \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ DATE OF ENTRY INTO U.S.: \_\_\_\_\_  
HOME COUNTRY: \_\_\_\_\_

**PERSONAL HEALTH STATUS**

Have you had or do you presently have:

No	Yes	
_____	_____	Asthma
_____	_____	Cancer
_____	_____	Depression
_____	_____	Diabetes
_____	_____	Eating disorder
_____	_____	Gastrointestinal disorder
_____	_____	Heart condition
_____	_____	High blood pressure
_____	_____	Menstrual difficulties
_____	_____	Muscle/joint problems
_____	_____	Panic attacks
_____	_____	Seizure disorder
_____	_____	Severe headaches
_____	_____	Thyroid disorder
_____	_____	Tuberculosis
_____	_____	Pregnancy (number _____)
_____	_____	Childbirths (number _____)
_____	_____	Other _____

If yes, explain. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Hospitalizations, surgeries, treatment of serious illness, accidents.**

Describe and give dates.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Physician's name \_\_\_\_\_  
Clinic \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_  
Phone \_\_\_\_\_

Are you currently taking medications/vitamins/herbal remedies, etc.  
\_\_\_ No \_\_\_ Yes If yes, list: \_\_\_\_\_  
\_\_\_\_\_

Are you currently using a contraceptive? \_\_\_ No \_\_\_ Yes  
If yes, name: \_\_\_\_\_

Are you allergic to:

No	Yes	
_____	_____	Penicillin
_____	_____	Other antibiotics _____
_____	_____	Other medications _____
_____	_____	Foods _____
_____	_____	Other (list) _____

Do you use tobacco?  
\_\_\_ No \_\_\_ Yes If yes, how much? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**FAMILY HEALTH HISTORY**

No	Yes	
_____	_____	Cancer _____
_____	_____	Diabetes _____
_____	_____	Heart condition _____
_____	_____	High blood pressure _____
_____	_____	Seizures _____
_____	_____	Tuberculosis _____
_____	_____	Other (type) _____

Complete Part II on other side of this form.

**IMMUNIZATION RECORD OF \_\_\_\_\_**

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**A. MMR (Measles, Mumps, Rubella): Two (2) doses after 1st birthday**

Date of 1st MMR \_\_\_\_\_

Date of 2nd MMR \_\_\_\_\_

**B. Polio: 4 doses of OPV or IPV**

Date of 4th dose \_\_\_\_\_

**C. Td (Tetanus, diphtheria): Booster dose every 10 years**

Date of last dose \_\_\_\_\_

**D. Hepatitis B: Three (3) doses**

Date: Dose 1 \_\_\_\_\_

Dose 2 \_\_\_\_\_

Dose 3 \_\_\_\_\_

**E. TB Mantoux: Within last 12 months**

Date read: \_\_\_\_\_

Result: \_\_\_\_\_ mm induration

\_\_\_\_\_ mm induration

\_\_\_\_\_ mm induration

**F. Other immunizations:**

Flu: Date: \_\_\_\_\_

Hepatitis A: Date Dose 1 \_\_\_\_\_ Date Dose 2 \_\_\_\_\_

Typhoid: \_\_\_\_\_

Meningitis \_\_\_\_\_

Varicella \_\_\_\_\_

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Student Signature

Date

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**IMPORTANT:** You are entitled to review or receive a copy of your health care record upon submitting a statement of informed consent.

Please mail completed form to: Student Health Services  
University of Wisconsin-Green Bay  
Student Services Building, Room 1400  
Green Bay, WI 54311-7001

Web site: <http://www.uwgb.edu/counselinghealth/>

Phone: 920-465-2380