



UNIVERSITY OF OREGON

UNIVERSITY HEALTH CENTER
Personal Health History

PLEASE RETURN FORM TO:
UNIVERSITY HEALTH CENTER
1232 UNIVERSITY OF OREGON
EUGENE, OR 97403-1232
(541) 346-2770

Name: last first middle

UO ID#: Date Entering University of Oregon:

Age: Date of birth: Gender:

Local address (if known): Phone #:

Permanent address: City/State/Zip:

State or country of birth: Citizenship:

Name of parent, guardian, or spouse: Relationship:

Address of above: Phone #:

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HEALTH REVIEW

Height: Weight: Current State of Health:

ALLERGIES TO MEDICATIONS:

ALLERGIES - Other: Do you receive immunotherapy?

Current medications:

Do you smoke? Yes No (quit date) Never Smoked

Table with 3 columns: Have you ever had, Yes, No. Rows include Attention Deficit/Hyperactivity Dis., Alcohol/Drugs Problems, Anemia, Anorexia/Bulimia/Eating Problems, Asthma, Cancer, Chronic Bronchitis, Cholesterol or lipid problems, Chronic Skin Disease, Convulsions, Seizures (epilepsy), Diabetes, Digestive Tract Disease, Fractures/Broken Bones, Gallbladder/Liver Disease, Glaucoma, Hay Fever, Headache (migraine), Heart Disease, Hepatitis/Yellow Jaundice, High Blood Pressure, HIV Infection, Kidney or Bladder Disease.

Table with 3 columns: Yes, No. Rows include Malaria, Mononucleosis or Infectious Mono, Orthopedic Problem, Pneumonia, Prolonged Depression or Anxiety, Radiation Treatment to head/neck, Sexually Transmitted Diseases, Speech, Hearing, or Vision Problem, Splenectomy, Stroke, Thrombophlebitis, Thyroid or Endocrine Disturbance, Transfusion of blood/blood product, Tuberculosis, Viral Hepatitis, Other.

Please comment on any yes answers listed above:

Have you ever been hospitalized? Yes No

Dates: Reason:

Dates & types of surgery:

I am currently under treatment for:

FOR WOMEN: Last Pap Smear Date Result

Last Mammogram Date Result

