Student Health Services
The Ohio State University
1875 Millikin Road
Columbus, OH 43210

Last	First	Middle Initial
Inst ID		

(Place patient label here)

MEDICAL HISTORY

Instructions: Please complete both sides of this form in black or blue ink.

General Information

Name _____ Birth Date _____/_____/_____
Last First Middle Month Day Year

Preferred Name _____ Previous Name _____
Last First Middle

Phone (_____)_____ State/Country of Origin _____

Sex Assigned at Birth (Select one): ◯ Male ◯ Female

Gender Identity (Select one): ◯ Male ◯ Female ◯ Transgender Man ◯ Transgender Woman ◯ Gender Fluid/Nonconforming

Other _____ Preferred Pronouns _____

Emergency Contact _____
Last Name First Name

Phone (_____)_____ Relationship _____

Social

Do you smoke/vape/use tobacco? ◯ Yes ◯ No How much in a typical week? _____

Do you smoke/vape/use marijuana? ◯ Yes ◯ No How much in a typical week? _____

Do you use other substances? ◯ Yes ◯ No How much in a typical week? _____

Do you drink alcohol? ◯ Yes ◯ No How much in a typical week? _____

Have you been sexually active in the past year? ◯ Yes ◯ No

Do you regularly use condoms? ◯ Yes ◯ No

Number of sexual partners in the past year? _____ Partners are: ◯ Male ◯ Female ◯ Both _____

Have you completed the HPV/Gardasil vaccine series? ◯ Yes ◯ No ◯ Not sure

Functional

Do you need help understanding written or spoken health information? ◯ Yes ◯ No

Do you have any special religious or cultural needs? ◯ Yes ◯ No Explain: _____

Do you have any special learning or communication needs? ◯ Yes ◯ No Explain: _____

Do you have any conditions/disabilities that limit your physical activities? ◯ Yes ◯ No Explain: _____

Last Name	First Name	Birth Date

Medical/Family

Please indicate with a check mark (√) if you or a family member (parents, siblings, grandparents, aunts, uncles) has had any of the following:

Medical Condition	You	Family	Specify family member & condition
☐ **NONE**			
Acne	☐	☐	
ADD/ADHD	☐	☐	
Alcoholism/Drug Abuse	☐	☐	
Anemia/Blood Disease/Clotting Disorder	☐	☐	
Anxiety, Depression, Eating Disorder	☐	☐	
Asthma	☐	☐	
Cancer	☐	☐	
Diabetes	☐	☐	
Heart Attack/Heart Disease/Heart Surgery	☐	☐	
Hepatitis	☐	☐	
High Blood Pressure	☐	☐	
HIV	☐	☐	
Migraine Headaches	☐	☐	
Seizure Disorder	☐	☐	
Sexually Transmitted Infections	☐	☐	
Stomach / Intestinal Problems	☐	☐	
Stroke	☐	☐	
Thyroid Disease	☐	☐	
Tuberculosis	☐	☐	
List other medical problems currently under treatment (BE SPECIFIC)	☐	☐	

Surgeries

Please list all hospitalizations, surgeries, and traumas:

Hospitalization	Reason	Date	Surgery	Date	Trauma	Date
☐ **NONE**			☐ **NONE**		☐ **NONE**	

Women

Age at first menstrual period? _____ Are your periods regular? ◯ Yes ◯ No

Are you using birth control? ◯ Yes ◯ No If yes, name:

Have you had a women's exam? ◯ Yes ◯ No If yes, have you had an abnormal pap? ◯ Yes ◯ No

Number of Pregnancies ____ Number of Miscarriages ____ Number of Abortions ____ Number of Ectopic Pregnancies ____

Signature

Patient Signature: _____ Today's Date: _____

Reviewed by Provider_____ Date_____