University Health Center
Student Affairs
UNIVERSITY OF GEORGIA

UNIVERSITY HEALTH CENTER
The University of Georgia
Athens, GA 30602-1755
(706) 542-1162

NAME: _____
UGA #: _____
GENDER: _____
Date of Birth: _____

MY HEALTH HISTORY

Ability & Disability
- ☐ Hearing Impaired
- ☐ Learning Disability
- ☐ Mobility/Wheel Chair
- ☐ Non-correctable Visual Impairment

Blood Disorders
- ☐ Bleeding Disorder
- ☐ Blood Clots/Phlebitis

Bone and Joint Problems
- ☐ Arthritis
- ☐ Back Pain, chronic
- ☐ Lupus

Cancer
- ☐ Leukemia or Lymphoma
- ☐ Melanoma
- ☐ Testicular Cancer

Endocrine (gland)
- ☐ Diabetes
- ☐ Thyroid Disorder

Eye/Vision
- ☐ Glaucoma
- ☐ Wear glasses or contacts

Gastrointestinal/Stomach
- ☐ Inflammatory Bowel Disease

Heart/Cardiovascular
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Passed out with exercise
- ☐ Stroke

Infections
- ☐ Hepatitis B or C
- ☐ Immunocompromising Illness

Infections - continued
- ☐ Mononucleosis
- ☐ Sexually Transmitted Infection
- ☐ Tuberculosis or Positive Skin Test
- ☐ COVID-19

General Health
- ☐ Use Tobacco
- ☐ Drink Alcohol
- ☐ Use recreational drugs
- ☐ Use caffeine or energy drinks

Mental Health
- ☐ Alcoholism/Drug Abuse
- ☐ Anxiety Disorder
- ☐ Bipolar Disorder (Manic/depression)
- ☐ Depression
- ☐ Eating Disorder

Neurological (Brain)
- ☐ Attention Deficit
- ☐ Migraine Headaches
- ☐ Seizure

Respiratory/Breathing
- ☐ Asthma (including exercise-induced asthma)
- ☐ Cystic Fibrosis

Urinary
- ☐ Kidney Stones
- ☐ Polycystic Kidney Disease
- ☐ Urinary Infections (Cystitis)

Language
- ☐ My primary language (if not English)_____

Height_____
Weight _____

Explain any items you have checked in the comment section below. Include any additional significant illnesses.

Medication: List all medications you take regularly, including birth control pills, non-prescription drugs and herbal preparations

Name of Medication	Dosage of Medication

Allergies: List any allergic or other significant reactions to medication.

Medication causing Allergy	Type of Reaction	Approximate Date of Onset

Surgery, significant injuries, hospital stays: Describe and include dates.

Description	Approximate Date

Family History: Complete the fields to the best of your knowledge for family members. Include heart disease, high cholesterol, diabetes, high blood pressure, tuberculosis, stroke, alcoholism, depression, other mental illness, and cancer (specify type). **Are you adopted?** ☐ Yes ☐ No

1. Father: Year of Birth:_____ **Occupation:**_____ **Age at Death(if deceased):** _____
Cause of Death (if deceased): _____

Medical Problems	Approximate Onset Date	Comment

2. Mother: Year of Birth:_____ **Occupation:**_____ **Age at Death(if deceased):** _____
Cause of Death (if deceased): _____

Medical Problems	Approximate Onset Date	Comment

3. Siblings: 1st Sibling Year of Birth:_____ **2nd Sibling Year of Birth:**_____ **3rd sibling Year of Birth:** _____
Age at Death(if deceased):_____ **Cause of Death (if deceased):** _____

Medical Problems	Approximate Onset Date	Comment