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

Last	First	Middle Initial

Inst ID

(Place patient label here)

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

General Info

Name _____ Birth Date ____/____/____
First MI Last Month Day Year

Previous Name _____ Preferred Name: _____
First MI Last

Primary Phone (_____)_____-_____ Secondary Phone (_____)_____-_____

Country of Origin U.S./ _____ Gender: ☐Male ☐Female ☐Transgender

Person to notify in case of emergency: _____
First MI Last

Phone (_____)_____-_____ Relationship to you _____

Medications

Please list current prescription and non-prescription medications, vitamins, supplements, home remedies, and herbs:

Medication/Vitamin/Other	Dose	Times per Day
☐ **NONE**		

Medication/Vitamin/Other	Dose	Times per Day

Allergies

Please list all allergies or reactions to medicines/foods/seasonal/other agents:

Medicine/Food/ Seasonal/Other Agent	Reaction or Side Effect
☐ **NONE**	

Medicine/Food/ Seasonal/Other Agent	Reaction or Side Effect

Functional

Do you need help understanding written or spoken health information? ☐Yes ☐No
Do you have any special religious or cultural needs? ☐Yes ☐No
If yes, please explain: _____
Do you have any special learning or communication needs? ☐Yes ☐No
If yes, please explain: _____
Do you have any conditions or disabilities that limit your physical activities? ☐Yes ☐No
If yes, please explain: _____

Social

Do you smoke/use tobacco? ☐Yes ☐No If yes, list quantity/type in typical day: _____
Do you drink alcohol? ☐Yes ☐No If yes, list quantity in typical week: _____
Do you use recreational drugs? ☐Yes ☐No
Have you been sexually active in the past year? ☐Yes ☐No
If yes: Do you regularly use condoms? ☐Yes ☐No
Number of sexual partners in the past year? _____ Partners are: ☐Male ☐Female ☐Both

Nutrition

Do you eat a well-balanced diet? ☐Yes ☐No
Do you feel you need to change your diet? ☐Yes ☐No
Are you satisfied with your weight? ☐Yes ☐No

Continued on next page **Continued on next page** **Continued on next page**

Last Name	First Name

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**	☐	☐	
ADD/ADHD	☐	☐	
Alcoholism / Drug Abuse (CIRCLE CONDITION)	☐	☐	
Anemia/Blood Disease/Clotting Disorder (CIRCLE CONDITION)	☐	☐	
Anxiety, Depression, Eating Disorder (CIRCLE CONDITION)	☐	☐	
Asthma	☐	☐	
Cancer	☐	☐	
Diabetes	☐	☐	
Heart Attack/Heart Disease/Heart Surgery (CIRCLE CONDITION)	☐	☐	
Hepatitis	☐	☐	
High Blood Pressure	☐	☐	
HIV	☐	☐	
Migraine Headaches	☐	☐	
Seizure Disorder	☐	☐	
Sexually Transmitted Infections	☐	☐	
Stomach / Intestinal Problems (CIRCLE CONDITION)	☐	☐	
Stroke	☐	☐	
Thyroid Disease	☐	☐	
Tuberculosis	☐	☐	
List other medical problems currently under treatment (BE SPECIFIC)	☐	☐	

Surgeries

Please list all hospitalizations, surgeries, and traumas:

Hospital Name	Reason	Date	Surgery	Date	Trauma	Date
☐ **NONE**			☐ **NONE**		☐ **NONE**	

Dental Care

Do you see your dentist regularly? ☐Yes ☐No Date of last dental visit: _____

Date of last dental cleaning: _____ Date of last dental x-rays: _____

How often do you brush? ☐After meals ☐Twice a day ☐Once a day ☐Weekly ☐Monthly ☐Before dental visits

Do you use fluoridated toothpaste? ☐Yes ☐No

How often do you floss? ☐After meals ☐Twice a day ☐Once a day ☐Weekly ☐Monthly ☐Before dental visits

Typical foods eaten between meals: _____

Typical beverages between meals: ☐Alcohol ☐Chocolate milk ☐Coffee ☐Energy drinks ☐Hot chocolate ☐Milk ☐Punch/Kool-Aid ☐Sugar free soda ☐Soda ☐Sports drinks ☐Tea ☐Water

How often do you chew/suck on hard candy, cough drops, mints? ☐Constantly ☐Hourly ☐Daily ☐Occasionally ☐Rarely ☐When sick ☐Never

Primary source of drinking water? ☐Bottled ☐Flavored bottled ☐City water ☐Filtered city water ☐Well water ☐Filtered well water

Women

For Women only:

Are you using contraception? ☐Yes ☐No If yes, what: _____

Have you received the HPV vaccination? ☐Yes ☐No

Have you had a pap? ☐Yes ☐No If yes, have you had an abnormal pap? ☐Yes ☐No

# of Pregnancies _____ # of Miscarriages _____ # of Abortions _____ # of Ectopic Pregnancies _____

Are you currently breastfeeding? ☐Yes ☐No

Signature

SIGNATURE _____ TODAY'S DATE ___/___/___

Reviewed by Provider _____ Date_____