UVU STUDENT HEALTH SERVICES
UTAH VALLEY UNIVERSITY

MEDICAL INTAKE FORM

Name: _____ **Date:** _____

Medication Allergies: Do you have any allergies to medication(s)? Yes No
If yes, list medication(s) and reaction(s): _____

Hospitalizations / Surgeries (describe): _____

Injuries / Accidents (describe): _____

MEDICAL HISTORY

Do you now, or have you in the past, had problems with any of the following:						
SKIN	Rashes					
HEAD	Head Injury	Concussion	Loss of Consciousness (Passing Out)			
EYES	Blurred or Double Vision		Eye Infections or Disease			
EARS, NOSE / SINUS	Ear Pain or Infections		Bloody Noses	Hearing Loss	Hay fever / Allergies	
MOUTH / THROAT	Hoarseness	Pain	Dental Problems			
NECK	Swelling	Pain	Lumps			
RESPIRATORY	Asthma	Cough	Bronchitis	High Blood Pressure	Shortness of Breath	
	Pneumonia	Bronchitis	Swelling of Hands of Feet		Heart Murmur	
	Chest Pain	Palpitations	Tuberculosis / Positive Test		Rheumatic Fever	
GASTRONINTESTINAL	Ulcers	Heartburn	IBS	Nausea or vomiting	Diarrhea or Constipation	
	Jaundice	Hepatitis	Gallbladder Disease			
GENITORINARY	Kidney Stones	Hernia	Blood In Urine,	STD	Painful Urination	
NEUROLOGICAL	Headaches	Seizures	Dizziness	Memory loss		
	Numbness or Tingling		Loss Of Coordination			
MUSCULOSKELATAL	Joint Pain	Muscle Pain	Stiffness Or Swelling	Back Problems		
ENDOCRINE	Diabetes	Recent Weight Gain Or Loss		Cold or Heat Intolerance		
	Thyroid Disorder		Extreme Thirst			
HEMATOLOGIC	Anemia	Leukemia	Bruise Easily	Blood Clots		
PSYCHIATRIC	Irritability	Nervousness	Depression or Mood Changes	Difficulty Concentrating		
	ADD/ADHD	Sleep Problems				
OTHER	Mononucleosis	Fibromyalgia	HIV	Cancer or Tumors	Immune System Problems	

List any other illness or symptom not included above: _____
_____

Females Only: Are you pregnant? Yes No Are you planning pregnancy? Yes No
Menstruation: Regular Irregular Problems

SOCIAL HISTORY

Have you ever used illicit drugs (i.e. marijuana, cocaine or amphetamines)? Yes No
If so, which drug(s)? _____

Do you have a regular exercise program? Yes No If so, list activity and frequency: _____
_____

Do you drink alcoholic beverages? Yes No If so, list amount and frequency: _____
Do you smoke or use smokeless tobacco? Yes No If so, list number of packs per day: _____

Are you currently, or have you been sexually active? Yes No If yes, do you use contraception? Yes No

Have you ever been assaulted verbally, sexually, or physically? Yes No
If yes, did you sustain any injuries (please list): _____

Are you currently seeing a therapist, counselor, psychologist or psychiatrist? Yes No

Have you been outside of the U.S. within the last 12 months? Yes No

Do you ever withhold food, exercise to excess, binge and purge, or use laxatives/diuretics to lose weight?
Yes No If yes, please explain: _____

FAMILY HISTORY

Does anyone in your family have any of the following? (Include parents, grandparents, siblings, and children)

Alcoholism	Diabetes	Mental Illness	Arthritis	Migraines	Asthma
Heart Disease	Thyroid Disease	Bleeding Disorder	High Blood Pressure	Stroke	Cancer
Kidney disease	Ulcers	Epilepsy	Other: _____		

Please check one: From: Utah County Utah Out of State International Faculty Staff