Texas A&M International University Student Health Services
Health History Form

Name: _____ Student ID: _____

Date of birth: _____ Gender: Male/Female/Trans/Nonbinary/No answer

Address: _____

City, State: _____ Zip Code: _____

Phone: (home) _____ (cell) _____

Health insurance: YES or NO Insurance provider: _____

Emergency contact: _____ Relationship: _____

Emergency contact phone: (home) _____ (cell) _____

MEDICAL HISTORY

Medical conditions you have been diagnosed with: _____

Are you currently under the care of a doctor: YES or NO

Name of doctor: _____

Allergies: YES or NO Please list here: _____

Medications: _____

Have you had surgery: YES or NO Please list here: _____

Family History

Y	N		Member of family with illness/disease
☐	☐	Alzheimer's	_____
☐	☐	Breast cancer	_____
☐	☐	Coronary disease	_____
☐	☐	Cervical cancer	_____
☐	☐	Colon cancer	_____
☐	☐	Depression	_____
☐	☐	Diabetes	_____
☐	☐	Glaucoma	_____
☐	☐	High cholesterol	_____
☐	☐	High blood pressure	_____
☐	☐	Ovarian cancer	_____
☐	☐	Prostate cancer	_____
☐	☐	Seizure disorder	_____
☐	☐	Skin cancer	_____
☐	☐	Thyroid dysfunction	_____

Social History

☐ Married ☐ Single
☐ Divorced ☐ Widow(er)
☐ Lives Alone ☐ Separated

Do you: Smoke - YES or NO
Drink Alcohol - YES or NO
Use recreational drugs - YES or NO

Do you have children? YES or NO
Number of children: _____

Religious Preference: _____ or NONE

Signature: _____ Date: _____