NMC | Campus Health

Nebraska Methodist College
720 N. 87th Street
Omaha, NE 68114-3426
(402) 354-7211
Fax: 354-7265
campushealth@methodistcollege.edu

# HEALTH HISTORY

Name _____ Preferred Name _____ Program _____

Address _____ City/State/Zip _____

Phone _____ DOB _____ Gender _____

Emergency Contact _____ Relationship _____ Phone _____

Primary Physician _____ Phone _____ Pharmacy _____

**MEDICAL HISTORY**: Do you have a present or past history of the following? Check all that apply

- ☐ Abnormal Pap Test
- ☐ ADD/ADHD
- ☐ Alcohol/Drug Abuse
- ☐ Anemia
- ☐ Asthma
- ☐ Back Problems
- ☐ Cancer
- ☐ Contacts/Glasses
- ☐ Depression/Anxiety
- ☐ Diabetes
- ☐ Drug/Alcohol Dependence
- ☐ Eating Disorder
- ☐ Fainting
- ☐ Headache/Migraines
- ☐ Head Injury/Concussion
- ☐ Hearing Deficit
- ☐ Heart Disease/Murmur
- ☐ Hernia
- ☐ High Blood Pressure
- ☐ Joint Injury
- ☐ Kidney Disease
- ☐ Recurrent UTI
- ☐ Seizure Disorder
- ☐ Sexually Transmitted Infection
- ☐ Sleep Difficulties
- ☐ Stomach Issues
- ☐ Thyroid Disorder
- ☐ Tuberculosis

Please provide explanation or more information on issue indicated above:

_____

Current Medications:

_____

_____

_____

Allergies/Anaphylaxis/Sensitivities:

_____

Hospitalizations/Surgeries:

_____

**FAMILY HISTORY**: Please indicate relationship

- ☐ Asthma_____
- ☐ Alcohol/Drug Abuse_____
- ☐ Cancer_____
- ☐ Diabetes_____
- ☐ Heart Disease_____
- ☐ High Blood Pressure_____
- ☐ Thyroid Disease_____
- ☐ Death before age 50_____
- ☐ Mental Illness_____
- ☐ Elevated Cholesterol_____

**SOCIAL HISTORY:**

Do you use tobacco/vaping products? ◯ Yes ◯ No Type? _____ How long? _____ Amount? _____

Date quit _____ Concerns with use? ◯ Yes ◯ No

Do you drink alcohol? ◯ Yes ◯ No Number of drinks/week: _____

Do you use marijuana or recreational drugs? ◯ Yes ◯ No Concerns with use? ◯ Yes ◯ No

Do you wear a seatbelt? ◯ Yes ◯ No How often do you exercise/Type? _____

Will you need medical assistance or physical disability accommodations? ◯ Yes ◯ No _____

Signature: _____Date: _____

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