CHRISTOPHER NEWPORT UNIVERSITY

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HEALTH & WELLNESS SERVICES

Offered in partnership with Riverside Health System

RETURNING PATIENT HEALTH INFORMATION FORM

***If you are 18 years of age or older, your UHWS Medical Records will be kept for six (6) years or until you graduate beginning with your first visit in UHWS.*
**If you are under 18, your records will be kept for six years beginning with your first visit after turning 18 years old.*

Please be aware you have the right, at any time, to obtain further medical advice from a health professional of your choice including off campus options.

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Please list any changes in the information below:

__________/________/__________
Date

Name: ____ **Age:** ______________
LAST **FIRST** **MIDDLE**

Preferred to be contacted by: Cell phone / email / home phone

Marital Status: (circle one) S / M / W / D / Sep **Sex:** (circle one) M / F / T

Race: (circle one) Asian / Hispanic / Caucasian /Black or African American / Native American / Chinese / Filipino / Japanese Native Hawaiian / Pacific Islander / Multiracial / Declined

Preferred Language Spoken: ___________________________

Ethnicity: (circle one) Hispanic or Latino / Non-Hispanic or Latino / Other or Undetermined / Declined

Employment Status: (circle one) Student / (Fac-staff) Full-time / (Fac-staff) Part-Time

YOUR PERSONAL HEALTH HISTORY

- **ALERGIES TO MEDICINES, FOOD, OTHER:** ❑ Yes ❑ No If yes please list:

1. ______________ 2. ______________ 3. ______________ 4. ______________5.________________

- **MEDICATIONS: (Please List all Prescriptions, Over-the-Counter, Vitamins, Herbals, Performance enhancers, etc. you are currently taking.)**

DRUG NAME & STRENGTH:	DOSE:	DRUG NAME & STRENGTH:	DOSE:
______________________	__________	______________________	______________
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______________________________ __________________ ____________________________________ _______________________

______________________________ __________________ ____________________________________ _______________________

______________________________ __________________ ____________________________________ _______________________

Do you have any special spiritual, religious, or cultural needs? ☐ **No** ☐ **Yes Explain**____________________________________

____

Are you on a special diet? ❑ Yes ❑ No If so, what type? ____

____

- **YOUR MEDICAL HISTORY**

Please circle if you have or, previously exhibited, any conditions / symptoms listed below:

1. High Blood Pressure
2. Diabetes
3. Cancer
4. Heart Disease
5. Shortness of Breath
6. Swollen Ankles
7. Palpitations
8. Lightheadedness
9. Stroke
10. High Cholesterol
11. Chest / Discomfort
12. Fever, chills, sweats
13. Body Art
14. Pneumonia
15. Persistent Cough
16. Tuberculosis (TB)
17. Asthma
18. Hay fever
19. Indigestion / Heartburn
20. Abdominal Discomfort
21. Change in appetite
22. Constipation or diarrhea
23. Unexplained weight gain
24. Unexplained weight loss
25. Blood in stool
26. Chickenpox
27. Ulcers
28. Hemorrhoids
29. Gallbladder Disease
30. Hepatitis / Liver disease
31. Thyroid Disease
32. Seizures
33. Headaches
34. Incontinence
35. Kidney Diseases
36. Kidney Stones
37. Difficulty urinating
38. Urine infections
39. Mononucleosis
40. Arthritis
41. Blood Disorder
42. Sickle Cell
43. Blood Clots
44. Anemia
45. Anxiety
46. Depression
47. Skin Diseases
48. Hearing difficulty
49. Gout
50. Low back problems
51. Glasses or contacts
52. Glaucoma or cataracts

Any problems not listed above: ____

- **VACCINATION HISTORY**

Tetanus Immunization ❑ Yes ❑ No When? _________
Flu Immunization ❑ Yes ❑ No When? _________
Meningitis ❑ Yes ❑ No When? _________

OPERATIONS: ___No ___Yes (please list)

OTHER HOSPITALIZATIONS: ___No ___Yes (please list)

TYPE OF OPERATION	WHEN		REASON	WHEN

- **FEMALE HISTORY**

Date of last menstrual period ____

FAMILY HISTORY: Has any member of your family (including parents, grandparents, and siblings) had the following?

Illness	Which Family Member	Approximate Age When Diagnosed
Cancer (describe type)		
High Blood Pressure		
Heart Disease		
Diabetes		

Stroke		
Mental Illness (anxiety, depression, etc)		
Blood / Clotting disease		
Anorexia / Bulimia (circle all that apply)		
Addiction / Drugs / Alcohol (circle all that apply)		
Sudden Death		
Overweight		
Other:		

PREVENTION HISTORY

Do you smoke or use tobacco products? ❑ Yes ❑ No Type____________Packs per day? ______ Quit?__________

Do you drink alcoholic beverages? ❑ Yes ❑ No How many?__________ How often?__________________

Do you exercise? ❑ Yes ❑ No How many times / week? __________________

Do you wear seat belts? ❑ Yes ❑ No

Do you wear a bicycle or motorcycle helmet? ❑ Yes ❑ No

Have you ever used, or are you using drugs? (marijuana, cocaine, crack, etc)? ❑ Yes ❑ No

If Yes please list: ____

Any behaviors which would increase your risk of AIDS? (IV drug use, unprotected intercourse, same sex relationship)
❑ Yes ❑ No If yes, list ____

Do you own a gun? ❑ Yes ❑ No

Are you an organ donor? ❑ Yes ❑ No

Have you ever been emotionally, physically or sexually assaulted?
❑ Yes ❑ No

Please sign below:

____ ______/______/______

Signature *Date*