Date________________________

STUDENT HEALTH CLINIC
Medical History Form

Welcome to the Laramie County Community College Student Health Clinic. In our attempt to provide efficient care for you at your appointment, we encourage you to fill out this form prior to your visit with the provider. Thank you

Patient Name	Date of Birth

Past Medical History

☐ Weight Loss / Gain	☐ Stomach / Intestinal Problem	☐ Eating Disorder
☐ Vision Problems	☐ Colon Problems	☐ Hereditary Disease
☐ Hearing Problems	☐ Thyroid Problems	☐ Neurological Problems / Seizures
☐ Headaches	☐ Diabetes	☐ Anemia
☐ Heart Problems	☐ Liver Problems	☐ Cancer transmitted diseases
☐ Blood Clot or Stroke	☐ Kidney / Urinary Problems	☐ Other
☐ High Blood Pressure	☐ Muscle / Bone / Joint	
☐ High Cholesterol	☐ Sexually Problem	
☐ Asthma	☐ Skin Problems	
☐ Lung Problems	☐ Depression / Mental Health Problem	

Describe any of the checked problems:

Allergies

Food / Environment / Drug Allergies	Reaction

Medications

Name of Medication	Dose	When do you take this medication each day?

Social History

Do you smoke?	☐ Yes ☐ No	If yes, how many packs per day?_______ Number of years that you have smoked?_______
Do you use chewing tobacco?	☐ Yes ☐ No	If yes, how many cans per week?_______
Do you use street drugs?	☐ Yes ☐ No	
Do you use alcohol?	☐ Yes ☐ No	Number of alcoholic drinks per week/day:_______/_______
Are you sexually active?	☐ Yes ☐ No	
Do you exercise regularly?	☐ Yes ☐ No	What type and how often?______________________________