UNIVERSITY OF DALLAS

Personal & Family History
University of Dallas Health Form

ALL new students are **REQUIRED** to complete each page. Do not postpone your submission. **Registration will NOT be complete without all pages of this form.**

For the term beginning:

☐ Fall of 20_____ ☐ Spring of 20_____

STUDENT INFORMATION

To the student: This information will not affect your scholastic status. It will be used, if necessary, as an aid to provide health care while you are a student and as proof of immunization for the state of Texas. **This information is strictly for the use of the Student Health Services Center and will not be released to anyone without your knowledge and consent.**

Last Name	First Name	Sex	Date of Birth

Email Address	Cell Number	Home Number

Street Address	Apt. Number

City	State	Zip Code

UD Student ID# (If non-US citizen, please specify citizenship)

FAMILY HISTORY

	Age	State of Health	Occupation	Age at Death	Cause of Death	List any relatives who have had:	
Father						Allergies/Hay Fever:	
Mother						Anxiety/Depression:	
Brothers						Asthma:	
						Cancer (type):	
						Diabetes:	
Sisters						Epilepsy:	
						High Blood Pressure:	
						High Cholesterol:	

PERSONAL HISTORY

Please check if you have had any of the following (include details and dates below).

Yes		Yes		Yes		Yes	
	Allergies to Medication		Heart Problems		Anxiety		Tumor, Cancer
			High Blood Pressure		Depression		Surgery:
	Chicken Pox		Sickle Cell Disease/Trait		Dizziness/Fainting		Date?
	Mononucleosis				Headaches, Recurrent		
	Malaria		Stomach/Intestinal Problems		Weakness/Paralysis		Females only:
	Tuberculosis		Gallbladder Disease		Worry/Nervousness		Irregular Periods
			Gum/Tooth Trouble				Severe Cramps
	Allergy/Hay Fever		Weight Loss/Gain		ADD/ADHD		Excessive Flow
	Asthma				Learning Difficulties		
	Ear, Nose, Throat Problems		Back Problems				Other:
	Eye Problems		Joint disease/Injury				

Have you ever had illness or injury other than noted above?

___Yes ___No Give details →

Have you been treated by a psychiatrist, psychologist or other mental health practitioner?

___Yes ___No

Have you ever been hospitalized for any physical or emotional disorder?

___Yes ___No Give details →

Do you have any *serious* dietary problems?
___Yes ___No Give details →

REMARKS OR ADDITIONAL INFORMATION
If you answered "YES" to any question on this page please explain below:
(Use additional sheet if necessary).

PARENT Signature (acknowledging review if student under 25) **Date**

STUDENT Signature (required) **Date**