Nicholls State University Health Services
P.O. Box 2054
Thibodaux, LA 70310
Phone 985.493-2600
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Patient Health History Form

Patient Name_____ **ID#**_____ **Date of Birth**_____

Drug Allergies ☐ No drug allergies

Allergy	Reaction

Please list any medications that you are currently taking: *If needing additional space, please attach list.

Medication Name	Dose	Frequency

Gender Identity and Sexual Orientation

What sex were you assigned at birth on your original birth certificate?

- ☐ Male
- ☐ Female

What is your current gender identity?

- ☐ Male
- ☐ Female
- ☐ Transgender Male/Trans Man/Female-to-Male (FTM)
- ☐ Transgender Female/Trans Woman/Male-to-Female (MTF)
- ☐ Genderqueer, neither exclusively male or female
- ☐ Additional Gender Category/Other (Please specify)

_____

- ☐ Choose not to disclose

Preferred Pronouns:

- ☐ He/Him
- ☐ She/Her
- ☐ They/Them
- ☐ Other_____

Do you think of yourself as:

- ☐ Straight or heterosexual
- ☐ Lesbian, gay, or homosexual
- ☐ Bisexual
- ☐ Something else
- ☐ Don't know
- ☐ Choose not to disclose

(COMPLETE REVERSE SIDE ALSO)

Personal History

Are you adopted: ☐ Yes ☐ No

Are you a member of Bridge to Independence? ☐ Yes ☐ No

☐ Acne (on medication)	☐ Hay fever, Hives, seasonal allergies	☐ Seizure
☐ ADD/ADHD	☐ Head Injury w/unconsciousness	☐ Sexually Transmitted Infections
☐ Anemia	☐ Heart Disease	☐ Sickle Cell Disorder
☐ Anxiety/Depression	☐ Hepatitis	☐ Sinusitis
☐ Asthma	☐ High Blood Pressure	☐ Sleep Disorders
☐ Autism Spectrum Disorder/Asperger	☐ Kidney Disease/Stones	☐ Stomach or Intestinal Trouble
☐ Blood Clotting Disorder	☐ Lyme Disease	☐ Suicide Attempts
☐ Cancer/Tumor	☐ Malaria	☐ Thyroid Disease/Endocrine Disorders
☐ Concussion	☐ Marfan Syndrome	☐ Tuberculosis
☐ Diabetes	☐ Migraines	☐ Vision/Hearing Impaired
☐ Disease of Joints	☐ Mononucleosis	☐ Other Medical Issues (please explain)
☐ Eating Disorder	☐ OCD	
☐ Eye Trouble	☐ Reflux, Ulcers, Colitis or IBS	

Have you ever been hospitalized? *	☐ Yes ☐ No	
Have you ever had an operation? *	☐ Yes ☐ No	
Do you have a disability (physical or learning)? *	☐ Yes ☐ No	
Do you have emotional health problems requiring therapy of medications? *	☐ Yes ☐ No	
Do you smoke? If yes how much?	☐ Yes ☐ No	
Do you have a past/present history of substance abuse? *	☐ Yes ☐ No	
Do you have a past/present history of alcohol abuse? *	☐ Yes ☐ No	
Do you have a past/present history of gambling? *	☐ Yes ☐ No	

**If YES, please explain*

Immediate Family Medical History -IF YES, please specify relationship:

Blood Diseases	☐ Yes ☐ No		High Blood Pressure	☐ Yes ☐ No	
Cancer	☐ Yes ☐ No		Kidney Disease	☐ Yes ☐ No	
Diabetes	☐ Yes ☐ No		Respiratory Disease	☐ Yes ☐ No	
Seizure Disorder	☐ Yes ☐ No		Other	☐ Yes ☐ No	
Heart Disease	☐ Yes ☐ No		**If yes, please explain*		

I understand that signing this form is acknowledgement that the above information is true and accurate.

Patient Signature: _____ **Date:** _____

Patient Representative: _____ **Relationship to patient:** _____