Health and Wellness Services
UNIVERSITY OF COLORADO **BOULDER**

PERSONAL HEALTH HISTORY

INSURANCE INFORMATION

Primary insurance: _____ **Subscriber's name:** _____

DOB: ____/_____/_____ **Address:** _____

Policy #: _____ **Group #:** _____

Customer service phone #: (_____) _____-_____

EMERGENCY CONTACT

Name: _____ **Phone #:** (_____) _____-_____

Relationship: _____

MEDICAL CONDITIONS

CURRENT MEDICATIONS

Medication (include prescriptions/over-the-counter)	**Dose**	**Strength**

ALLERGIES

Allergy	**Reaction**

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PERSONAL HEALTH HISTORY

MAJOR MEDICAL PROCEDURES

Previous hospitalizations, surgeries	**Date, location, procedure** (if applicable)

FAMILY HISTORY

Please indicate if any family members (parents, siblings, grandparents) have the following conditions. Use the following abbreviations to illustrate who:
M = Mother, **F** = Father, **S** = Sister, **B** = Brother, **MGM** = Maternal Grandmother, **MGF** = Maternal Grandfather, **PGM** = Paternal Grandmother, **PGF** = Paternal Grandfather, **O** = Other

Yes	**Who**	**Condition**	**Yes**	**Who**	**Condition**
		Diabetes			Lung cancer
		Heart disease			Alcoholism
		High cholesterol			Mental health
		Cervical cancer			Breast cancer
		Colon cancer			Skin cancer
		High blood pressure			Prostate cancer

ADDITIONAL NOTES
