
Student ID **Last Name** **First Name** **Alcohol EDU** __Y __N

Marital Status: Single Married Widowed Divorced Other

Ethnic Origin _____ **E-Mail Address** _____ **Birth date** _____

Local Address: Street Apartment Number City State Zip

Local Phone **Work Phone** **Parent's Phone** **Insurance Company**

Please check (✓) **Give dates when known:** **Medications you currently take:** _____

TB _____ Results _____ Measles _____

Tetanus _____ MMR _____ Mumps _____

Hepatitis A _____ Rubella _____

Hepatitis B _____ Chicken Pox _____

Meningitis _____

Do you use tobacco? Y / N # of years _____
 Type _____ Amt/day _____

Do you drink alcohol? Y / N # of years _____
 Exercise: Y / N Amt/day _____

Have you ever been sexually active Y / N

Have you ever : **Medications you currently take:** _____

Had a blood transfusion Y / N **Have you ever :** Had unprotected sex Y / N

Been an IV drug user Y / N Sex with an IV drug user Y / N

Abused other drugs Y / N Had Hepatitis Y / N
 Type A B C

Used recreational (street) drugs? Date of last use: _____

List Kinds: _____

Previous Medical History:
 Tonsillitis _____ Ulcers _____

Severe injuries requiring Hospitalization: _____

Any Surgeries: _____

	Self	Father	Mother	Brother/ sister	Grand- parents		Self	Father	Mother	Brother/ sister	Grand- parents
Alive						Epilepsy					
Cause of Death						Heart Disease					
Age of Death						Diabetes					
Mental Depression						Cancer					
Breast Disease/cancer						Asthma					
Hyperlipidemia (High cholesterol)						Hay Fever					
Thyroid problems						Arthritis					
Gall Bladder problems						Kidney Disease					
Phlebitis						Glaucoma					
Hepatitis						Stroke					
High Blood Pressure						Migraine					

Have you ever been?

Physically Abused?	___ Yes ___ No	Verbally Abused	___ Yes ___ No
Mentally abused?	___ Yes ___ No	A Victim of incest	___ Yes ___ No
Raped	___ Yes ___ No		___ Yes ___ No

Signature of Patient _____ Date _____

Signature of Reviewer _____ Date _____