

Other bone or joint problem
 Explain: _____

CHRONIC DISEASE
 Cancer
 Diabetes
 Inflammatory bowel disease
 Thyroid problems
 Other chronic disease
 Explain: _____

INFECTIOUS DISEASE
 Chickenpox
 Hepatitis A B C (circle one)
 Hepatitis chronic
 Measles
 Meningitis
 Mononucleosis
 Mumps
 Rheumatic fever
 Rubella
 Sexually transmitted disease (STD)
 Explain: _____
 Tuberculosis
 Whooping cough
 Other infectious disease
 Explain: _____

MENTAL HEALTH
 Anxiety
 Bipolar disorder
 Depression
 Difficulty with concentration
 Eating disorder
 Excessive mood changes
 Memory problems
 Sleep difficulty
 Other: _____

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	OTHER HEALTH PROBLEMS
<input type="checkbox"/>	<input type="checkbox"/>	Skin problems
<input type="checkbox"/>	<input type="checkbox"/>	Unexplained weight gain or loss
<input type="checkbox"/>	<input type="checkbox"/>	Other health problems
<input type="checkbox"/>	<input type="checkbox"/>	Explain: _____
<input type="checkbox"/>	<input type="checkbox"/>	WOMEN'S HEALTH
<input type="checkbox"/>	<input type="checkbox"/>	Age of onset of menstruation _____
<input type="checkbox"/>	<input type="checkbox"/>	Menstrual problems
<input type="checkbox"/>	<input type="checkbox"/>	Explain: _____
<input type="checkbox"/>	<input type="checkbox"/>	Use birth control
<input type="checkbox"/>	<input type="checkbox"/>	Specify: _____
<input type="checkbox"/>	<input type="checkbox"/>	No. of pregnancies _____
<input type="checkbox"/>	<input type="checkbox"/>	No. of live children _____
<input type="checkbox"/>	<input type="checkbox"/>	Other women's health problems
<input type="checkbox"/>	<input type="checkbox"/>	Explain: _____
<input type="checkbox"/>	<input type="checkbox"/>	LIFESTYLE
<input type="checkbox"/>	<input type="checkbox"/>	Alcohol use
<input type="checkbox"/>	<input type="checkbox"/>	_____ per day ___ wk ___ mo ___
<input type="checkbox"/>	<input type="checkbox"/>	Type: _____
<input type="checkbox"/>	<input type="checkbox"/>	Smoking/Tobacco use
<input type="checkbox"/>	<input type="checkbox"/>	Type: _____
<input type="checkbox"/>	<input type="checkbox"/>	Frequency: _____
<input type="checkbox"/>	<input type="checkbox"/>	Age when started: _____
<input type="checkbox"/>	<input type="checkbox"/>	Other drug use
<input type="checkbox"/>	<input type="checkbox"/>	_____ per day ___ wk ___ mo ___
<input type="checkbox"/>	<input type="checkbox"/>	What kind: _____
<input type="checkbox"/>	<input type="checkbox"/>	Physical Activity
<input type="checkbox"/>	<input type="checkbox"/>	What kind: _____
<input type="checkbox"/>	<input type="checkbox"/>	How much:
<input type="checkbox"/>	<input type="checkbox"/>	_____ per day ___ wk ___ mo ___
<input type="checkbox"/>	<input type="checkbox"/>	How long _____
<input type="checkbox"/>	<input type="checkbox"/>	Physical restrictions or limitations
<input type="checkbox"/>	<input type="checkbox"/>	Explain: _____
<input type="checkbox"/>	<input type="checkbox"/>	Cultural or religious issues
<input type="checkbox"/>	<input type="checkbox"/>	Explain: _____

Family History

Yes	No	Relationship
<input type="checkbox"/>	<input type="checkbox"/>	Alcoholism _____
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis _____
<input type="checkbox"/>	<input type="checkbox"/>	Asthma, hayfever, hives _____
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding disorder _____
<input type="checkbox"/>	<input type="checkbox"/>	Cancer _____
<input type="checkbox"/>	<input type="checkbox"/>	Death before age 50 _____
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes _____
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy / Seizures _____
<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease _____
<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure _____

Yes	No	Relationship
<input type="checkbox"/>	<input type="checkbox"/>	High cholesterol _____
<input type="checkbox"/>	<input type="checkbox"/>	Kidney trouble _____
<input type="checkbox"/>	<input type="checkbox"/>	Psychological problems _____
<input type="checkbox"/>	<input type="checkbox"/>	Stomach or bowel trouble _____
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems _____
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis _____
<input type="checkbox"/>	<input type="checkbox"/>	Other _____
<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____

Additional Information: _____

The above information is true and complete to the best of my knowledge and I am aware that deliberate misrepresentation may jeopardize my health. I understand that this information is confidential and is protected by law.

Signature of Student

Date

Health History forms are on-line!

No need to mail!

**To complete, go to www.hartshorn.colostate.edu,
click on “Fill out Medical History form” button.**

**You will still need to send in your immunizations with a
signature from a nurse or school health aide.**

For the convenience of those who do not have access to a computer, we have enclosed a health history form you may fill out and mail.

Minors (students under the age of 18) **must** send in *Authorization for Treatment of a Minor* signed by a parent or legal guardian. Please use form below.

Colorado State University
Hartshorn Health Service
Fort Collins, CO 80523-8031



Authorization for Treatment of a Minor

I am the parent or legal guardian of _____, currently a
minor, whose date of birth is ____/____/____.

I authorize Colorado State University Hartshorn Health Service to provide medical and/or mental health care to my son/daughter, including but not limited to, diagnostic examinations (including radiological and laboratory testing), tuberculosis screening, verification and/or administration of immunizations, and necessary medical treatment including minor surgical procedures, and mental health counseling.

I understand that should my minor child need more invasive diagnostic or surgical procedures, attempts will be made to contact me before such care is initiated.

I further understand that, once my child reaches the age of majority, my consent for treatment is no longer required.

Signature

Date

Printed name

Relationship