



Your **Personal** Health History  
**RICHARD BLAND COLLEGE**  
 Health & Wellness Clinic  
 11301 Johnson Road  
 Petersburg, VA 23805  
 Phone: (804)862-6225 Fax: 804-862-6490

**PERSONAL HEALTH HISTORY & CONSENT FOR TREATMENT**

Please answer all of the questions below to the best of your ability.

Please be aware that you have the right, at any time, to obtain further medical advice from a health professional of your choice including off campus options.

Banner Student ID # \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

LAST NAME	FIRST NAME	MI	Date of Birth: ____/____/____	
LOCAL ADDRESS:	STREET	CITY	STATE	ZIP
<u>Residence Hall:</u>				Local Telephone # ( )-____-____ Cell Phone # ( )-____-____
PERMANENT ADDRESS:	STREET	CITY	STATE	ZIP
				TELEPHONE: ( )-____-____
SOCIAL SECURITY NO.	AGE	Gender (Optional)	RELATIONSHIP STATUS (Optional) <input type="checkbox"/> Single <input type="checkbox"/> Domestic Partner Relationship <input type="checkbox"/> Married <input type="checkbox"/> Divorced/Sep <input type="checkbox"/> Widowed	EMAIL ADDRESS
<p>RACE/ETHNIC IDENTITY: Are you a non-resident alien? Yes__ No__            Are you Hispanic/Latino? Yes__ No__</p> <p>If <b>"No"</b>, please check <b>one</b> of the following:</p> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <input type="checkbox"/> American Indian or Alaska Native  <input type="checkbox"/> Asian  <input type="checkbox"/> Black or African American  <input type="checkbox"/> Native Hawaiian or Other Pacific Islander           </div> <div style="width: 45%;"> <input type="checkbox"/> White  <input type="checkbox"/> Two or more races  <input type="checkbox"/> Race and Ethnicity unknown           </div> </div>				
<b>EMERGENCY INFORMATION</b>				
<p>IN CASE OF EMERGENCY: <i>In the event of an emergency, I give permission to the staff of Health &amp; Wellness Clinic to contact the following individual(s):</i></p> <p>Name _____ Relationship to patient _____</p> <p>Address _____ Phone(s) _____</p> <p>City _____ State _____ Zip _____</p> <p>INSURANCE: (Optional) It is strongly advised that all students have some form of health insurance coverage while attending RBC.</p>				
INSURANCE COMPANY:			COMPANY ADDRESS:	
NAME OF POLICY HOLDER:			I.D. /GROUP NUMBER:	

List any **ALLERGIES** you have:  
Medications/Food/Environmental/Latex \_\_\_\_\_

List any **MEDICATIONS** you take:  
(Please list prescription & OTC  
Botanicals/Herbs/Nutritional Supplements)  
\_\_\_\_\_  
\_\_\_\_\_

List any previous significant **TRAUMA**:  
\_\_\_\_\_

Indicate any **Surgeries** you have had: \_\_\_\_\_  
\_\_\_\_\_

- |  |                                   |
|--|-----------------------------------|
| <input type="radio"/> Appendix         | <input type="radio"/> Gallbladder |
| <input type="radio"/> Tonsils          | <input type="radio"/> Tubes Tied  |
| <input type="radio"/> Organ Transplant | <input type="radio"/> Uterus      |
| <input type="radio"/> Piercing(s)      | <input type="radio"/> None        |
| _____                                  | <input type="radio"/> Heart       |
| <input type="radio"/> Hernia           |                                   |

List other \_\_\_\_\_

Do **YOU** have or have had in the past, any of the following medical problems?

- |   |   |
|---|---|
| <input type="radio"/> Acne                                | <input type="radio"/> High Blood Pressure                       |
| <input type="radio"/> ADD/ADHD                            | <input type="radio"/> High Cholesterol/<br>Triglycerides        |
| <input type="radio"/> Anorexia                            | <input type="radio"/> HIV/AIDS                                  |
| <input type="radio"/> Asthma/Lung Disease                 | <input type="radio"/> Hives                                     |
| <input type="radio"/> Anxiety Disorder (Panic<br>Attacks) | <input type="radio"/> Insomnia/Sleep Disorder                   |
| <input type="radio"/> Blood Disorder                      | <input type="radio"/> Migraine headaches                        |
| <input type="radio"/> Cancer/Skin                         | <input type="radio"/> Mononucleosis                             |
| <input type="radio"/> Diabetes                            | <input type="radio"/> Neurological Disease<br>(Stroke/Seizures) |
| <input type="radio"/> Depression                          | <input type="radio"/> Orthopedic problems<br>(Scoliosis)_____   |
| <input type="radio"/> Ear Problems                        | <input type="radio"/> Sinus Problems                            |
| <input type="radio"/> Eczema                              | <input type="radio"/> Stomach/Bowel problems                    |
| <input type="radio"/> Endocrine Disease (Thyroid)         | <input type="radio"/> Tuberculosis                              |
| <input type="radio"/> Gastric Reflux                      | <input type="radio"/> Urinary Infections/Kidney<br>Stones       |
| <input type="radio"/> Heart murmur<br>(MVP)               |   |
| <input type="radio"/> Hepatitis                           |   |

**Other problems not listed:** \_\_\_\_\_  
\_\_\_\_\_

**ASTHMA, please answer the following:**

Do you use an inhaler, and is it here with you? \_\_\_\_\_

Do you have a peak flow meter? (is it here with you?) \_\_\_\_\_

Do you wear Glasses/Contact lens/Hearing Aide/Prosthetic Devices? \_\_\_\_\_

Do you use tobacco products? Cigars/Smokeless Tobacco/Cigs  
\_\_ YES \_\_ NO

Packs per day \_\_\_\_\_ For \_\_\_\_\_ Years \_\_\_\_\_ Quit \_\_\_\_\_

Do you drink Alcohol? \_\_ YES \_\_ NO

Drinks per day \_\_\_\_\_ Drinks per week \_\_\_\_\_ Type \_\_\_\_\_

Do you take drugs not prescribed by a doctor? \_\_ YES \_\_ NO

Do you **EXERCISE**? How much \_\_\_\_\_

Do you wear a **SEAT BELT**? \_\_ YES \_\_ NO

How many hours of **SLEEP** do you get a night? \_\_\_\_\_

Have you ever been hit, kicked, touched or spoken to in a manner  
that made you feel uncomfortable? \_\_ YES \_\_ NO

Do any of the following medical problems run in your **FAMILY**?

- |                                     |                                     |   |
|-------------------------------------|-------------------------------------|---|
| <input type="radio"/> AIDS          | <input type="radio"/> Cancer (type) | <input type="radio"/> Pressure                |
| <input type="radio"/> Addiction     | _____                               | <input type="radio"/> Psychiatric<br>Disorder |
| <input type="radio"/> Drugs/Alcohol | <input type="radio"/> Diabetes      | <input type="radio"/> Stroke                  |
| <input type="radio"/> Arthritis     | <input type="radio"/> Heart         | <input type="radio"/> Sudden Death            |
| <input type="radio"/> Asthma/Lung   | <input type="radio"/> High Blood    |   |

Check any of the following that you have had **RECENTLY**:

- |  |  |
|--|--|
| <input type="radio"/> Abdominal pain           | <input type="radio"/> Frequency of urination     |
| <input type="radio"/> Ankle swelling           | <input type="radio"/> Heart palpitations         |
| <input type="radio"/> Blood in stool           | <input type="radio"/> Nasal Congestion/ bleeding |
| <input type="radio"/> Blood in urine           | <input type="radio"/> Nausea                     |
| <input type="radio"/> Chest pain               | <input type="radio"/> Pain w/urination           |
| <input type="radio"/> Constipation             | <input type="radio"/> Phlegm                     |
| <input type="radio"/> Cough                    | <input type="radio"/> Problems Sleeping          |
| <input type="radio"/> Diarrhea                 | <input type="radio"/> Recent vision changes      |
| <input type="radio"/> Difficulty Breathing     | <input type="radio"/> Shortness of breath        |
| <input type="radio"/> Difficulty Concentrating | <input type="radio"/> Sore Throat                |
| <input type="radio"/> Ear Pain                 | <input type="radio"/> Very tired                 |
| <input type="radio"/> Eye Pain                 | <input type="radio"/> Weakness                   |
| <input type="radio"/> Fever/Chills             | <input type="radio"/> Weight loss/gain           |
| <input type="radio"/> Flank pain               | <input type="radio"/> Wheezes                    |

**Male:**

- |                                |  |
|--------------------------------|--|
| <input type="radio"/> Rash     | <input type="radio"/> Testicle pain        |
| <input type="radio"/> STI/STDs | <input type="radio"/> Testicular Self Exam |

**Female:**

Last menstrual period \_\_\_\_\_  
Date of Last PAP SMEAR \_\_\_\_\_ Results \_\_\_\_\_  
Birth Control \_\_\_\_\_  
# of pregnancies \_\_\_\_\_ # of children \_\_\_\_\_  
Do you do SBE (Self Breast Exam)? \_\_ YES \_\_ NO  
Do you take Multivitamins/Folic Acid/Calcium? \_\_ YES \_\_ NO  
 Vaginal discharge  
 Ovarian Cysts  
 Endometriosis

Are you in a relationship w/another person now? \_\_ YES \_\_ NO

If yes, is this a good one for you? \_\_ YES \_\_ NO \_\_ NOT SURE

Gender of current sexual partner(s) check all that apply:

- |                            |                              |   |
|----------------------------|------------------------------|---|
| <input type="radio"/> Male | <input type="radio"/> Female | <input type="radio"/> Not currently<br>active |
|----------------------------|------------------------------|---|

Gender of PAST sexual partner(s) check all that apply:

- |                            |                              |   |
|----------------------------|------------------------------|---|
| <input type="radio"/> Male | <input type="radio"/> Female | <input type="radio"/> Not currently<br>active |
|----------------------------|------------------------------|---|

Your **Personal** Health History

Additional medical information about YOU:

- Headache
- Dizziness
- Numbness
- Depression
- Hallucinations
- Hot or Cold intolerance
- Excessive thirst
- Bleed excessively
- Bruise easily
- Passing out
- Seizures