Medical History Form

Name _____ Date of Birth _____Sex: F___ M ___

PID# _____ Phone _____ address/name of dorm _____

Email address_____

Notify in case of emergency:

List your allergies to drugs or food:	List current medications you are now taking
_____	and please include vitamins or supplements.
_____	

Neurological

YES NO

___ ___ dizziness or fainting
___ ___ headaches or migraines
___ ___ head injury or loss of consciousness
___ ___ history of seizures

explain _____

Eye, Ear, Nose, Throat

___ ___ vision and hearing change
___ ___ hay fever / seasonal allergies
___ ___ ear infection
___ ___ sinus problems
___ ___ frequent strep throat or mono
___ ___ other eye, ear, nose or throat problems

explain _____

Heart and Lungs

___ ___ asthma
___ ___ arrhythmia (irregular heart beat)
___ ___ pneumonia
___ ___ heart trouble or murmur
___ ___ high blood pressure
___ ___ shortness of breath or chronic cough
___ ___ other heart or lung problems

explain _____

Abdomen

YES NO

___ ___ irritable bowel
___ ___ diarrhea
___ ___ constipation
___ ___ jaundice
___ ___ kidney or bladder infection
___ ___ frequent heartburn
___ ___ hemorrhoids
___ ___ other abdominal problems

explain _____

Bones and Joints

___ ___ arthritis
___ ___ joint pain
___ ___ broken bones
___ ___ bone or joint injuries
___ ___ painful or swollen joints
___ ___ shoulder, elbow, wrist problem
___ ___ other bone or joint problems

explain _____

Chronic Disease

___ ___ cancer
___ ___ diabetes
___ ___ thyroid disease
___ ___ autoimmune disease

explain _____

Infectious Disease

Have you had any of these diseases in your lifetime.

YES NO

___ ___ chickenpox
___ ___ hepatitis A, B, or C
___ ___ measles
___ ___ mumps
___ ___ rubella
___ ___ meningitis
___ ___ mononucleosis
___ ___ rheumatic fever
___ ___ STD (sexually transmitted disease)
___ ___ tuberculosis
___ ___ whooping cough
___ ___ other infectious disease

explain _____

Other Health Problems

YES NO

___ ___ skin problems
___ ___ unexplained weight loss
___ ___ unexplained weight gain
___ ___ unexplained hair loss
___ ___ other health problems

explain _____

Womens Health

___ ___ menstrual problems
___ ___ use birth control _____how long

type _____

Womens Health cont.

Age at onset of menstruation _____
Number of pregnancies _____
Number of live children _____

YES NO

Lifestyle

___ ___ tobacco use _____ per day ____per week
___ ___ alcohol use _____ per day ____ per week
___ ___ drug use _____ type
___ ___ exercise _____times per week
___ ___ physical limitations

___ ___Condom Use

explain _____

Mental Health

YES NO

___ ___ anxiety
___ ___ depression
___ ___ eating disorder
___ ___ bipolar disorder
___ ___ memory problems
___ ___ difficulty with concentration
___ ___ excessive mood changes
___ ___ sleep difficulty

explain _____

_____

SURGERIES : *list all surgeries you have had in your lifetime*

_____ Year _____ _____Year _____

_____ Year _____ _____ Year _____

Family History

YES	NO		Relationship	YES	NO		Relationship
___	___	alcoholism	_____	___	___	high cholesterol	_____
___	___	arthritis	_____	___	____	kidney disease	_____
___	___	bleeding disorder	_____	___	____	psychological problems	_____
___	___	blood clots	_____	___	___	intestinal problems	_____
___	___	cancer	_____	___	___	thyroid problems	_____
___	___	diabetes	_____	___	___	tuberculosis	_____
___	___	heart disease	_____	___	___	epilepsy / seizures	_____
___	___	hypertension	_____				

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 patient / student Date