Print in Color or Grayscale Only
Using Adobe Acrobat Reader 8.0 or later

# Patient Medical History
## Age 13 and older

**STAFF:** Responses in boxes and handwritten items must be entered **MANUALLY**.

PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH (Month / Day / Year)

## Marking Instructions

Please use a #2 pencil.
Fill in the complete oval as shown...

**Please complete this history form. This will allow us to serve your health needs.**
**The information contained herein is strictly confidential. It will not be released unless you authorize us to do so.**

## SOCIAL HISTORY

**Tobacco Use**

What is your CURRENT smoking status (select one)? current smoker (every day) ○ | current smoker (some days) ○ | former smoker ○ | never smoked ○

How many packs per day do you smoke (or did you smoke)? less than 1 ○ | 1-2 ○ | more than 2 ○

How many years have you smoked (or did you smoke)? less than 5 ○ | 5 ○ | 10 ○ | 15 ○ | 20 ○ | 25 ○ | 30 ○ | 35 ○ | 40+ ○

Does anyone in your household smoke? yes ○ | no ○

Do you smoke cigars? currently ○ | in the past ○ | never ○

Number of cigars smoked per day: <1 ○ | 1 ○ | >1 ○

Do you use smokeless tobacco (chew / chewing tobacco)? currently ○ | in the past ○ | never ○

**Alcohol Use**

Do you consume alcohol? currently ○ | in the past ○ | never ○

Average number of drinks per week (now or in the past): 7 or less ○ | 8-14 ○ | 15+ ○

How often do you drink 4 or more drinks in a 24 hour period? once a week ○ | once a month ○ | rarely, but sometimes ○ | never ○

**Exercise**

Do you exercise regularly? yes ○ | no ○

If yes, number of times per week: occasionally ○ | 1-2 ○ | 3-4 ○ | 5-6 ○ | 7+ ○

If yes, length of time each session: <30 min. ○ | 30 min.-1 hr. ○ | 1-1½ hrs. ○ | >1½ hrs. ○

If yes, type(s) of activity: walking ○ | swimming ○ | cardio ○ | weightlifting ○ | jogging / running ○ | cycling ○ | other ○

**Sexual Activity**

Have you ever been sexually active (oral, genital, anal)? yes ○ | no ○

If yes, do you use condoms? always ○ | sometimes ○ | never ○

If yes, how many sexual partners have you had throughout your life? 1 ○ | 2-5 ○ | 6-10 ○ | 11-20 ○ | 21-50 ○ | 51+ ○

If yes, have you had any new sexual partners within the last year? yes ○ | no ○

Have you ever been TESTED for a sexually transmitted infection (STI or STD)? yes ○ | no ○

Have you ever had or been TREATED for a sexually transmitted infection (STI or STD)? yes ○ | no ○

Have you engaged in high risk behavior for sexually transmitted diseases? (e.g., more than one sexual partner, unprotected sexual contact, etc.) currently ○ | in the past ○ | never ○

Would you identify yourself as: heterosexual ○ | bisexual ○ | unsure ○ | gay / lesbian ○ | transgender ○ | prefer not to answer ○

**Other**

Do you live in campus or campus-affiliated housing? yes ○ | no ○

Do you live alone? yes ○ | no ○

Do you currently feel or have you felt harmed or afraid of someone else within the last year? yes ○ | no ○

Are you afraid of your partner or anyone else close to you? yes ○ | no ○

Intravenous (IV) drug use? currently ○ | in the past ○ | never ○

Other recreational drug use? currently ○ | in the past ○ | never ○

Do you have any tattoos? yes ○ | no ○

Do you have working smoke detectors in your home? yes ○ | no ○

Do you have a working carbon monoxide detector in your home? yes ○ | no ○

Do you always wear a seat belt? yes ○ | no ○

Do you have guns in your home? yes ○ | no ○

Number of children: 0 ○ | 1 ○ | 2 ○ | 3 ○ | 4 ○ | 5+ ○

Do you regularly use sunscreen? yes ○ | no ○

Do you wear a helmet when riding a bicycle or motorcycle? always ○ | sometimes ○ | never ○ | I do not ride a bicycle or motorcycle ○

Print in Color or Grayscale Only
Using Adobe Acrobat Reader 8.0 or later

# Patient Medical History
## Age 13 and older

STAFF: Responses in boxes and handwritten items must be entered MANUALLY.

## YOUR MEDICAL HISTORY

**Please indicate if YOU have a history of the following.**
Mark all that apply. If none, mark "**NO SIGNIFICANT MEDICAL HISTORY**."

| PAST | CURRENT | |
|---|---|---|
| | | **NO SIGNIFICANT MEDICAL HISTORY** |
| | | Abnormal Pap Smear |
| | | Alcohol Abuse |
| | | Allergies (Food) |
| | | Allergies (Insect) |
| | | Allergies (Seasonal) |
| | | Anemia |
| | | Anorexia |
| | | Anxiety |
| | | Arthritis |
| | | Asthma |
| | | Bipolar Disorder |
| | | Bleeding Disorder |
| | | Blood Clots |
| | | Broken Bone(s) |
| | | Bulimia |
| | | Cancer |
| | | Celiac Disease / Sprue |
| | | Concussion (Head Injury) |
| | | Congestive Heart Failure |
| | | COPD / Emphysema |
| | | Coronary Artery Disease |
| | | Crohn's Disease |
| | | Chlamydia |
| | | Depression |
| | | Diabetes Type 1 (Juvenile) |
| | | Diabetes Type 2 (Adult) |
| | | Drug Abuse |
| | | Glaucoma |
| | | Gonorrhea |
| | | Hearing Loss |
| | | Heart Attack |
| | | Heart Murmur |
| | | Hepatitis B |
| | | Hepatitis C |
| | | High Blood Pressure |
| | | High Cholesterol |
| | | HIV /AIDS |
| | | Hyperthyroidism (High Thyroid) |
| | | Hypothyroidism (Low Thyroid) |
| | | Irregular Heartbeat |
| | | Irritable Bowel Syndrome (IBS) |
| | | Kidney Stones |
| | | Leukemia |
| | | Lymphoma |
| | | Migraines (with visual or motor disturbance) |
| | | Migraines (without visual or motor disturbance) |
| | | Multiple Sclerosis |
| | | Narcotic Abuse |
| | | Osteoporosis |
| | | Ovarian Cyst |
| | | Pneumonia |
| | | Prostate Problems |
| | | Reflux / GERD |
| | | Rheumatoid Arthritis |
| | | Seizures / Convulsions |
| | | Sleep Apnea |
| | | Stomach Ulcer |
| | | Stroke / CVA of the Brain |
| | | Suicide Attempt |
| | | Tuberculosis (TB) |
| | | Positive Tuberculosis (TB) Test |
| | | Urinary Tract Infection(s) |
| | | Ulcerative Colitis |

**Have you ever been hospitalized?** (If yes, indicate what you were hospitalized for and when):

_____

**Other Disease, Cancer or Significant Medical Illness** (please specify):

_____

## SURGICAL HISTORY

**Please mark all surgeries you have had:**

- **I HAVE HAD NO SURGERIES**
- ACL Repair
- Ankle Surgery
- Appendectomy
- Back Disc Surgery
- Breast Augmentation
- Breast Biopsy
- Breast Reduction
- Colposcopy (Cervical Biopsy)
- Dental Surgery
- Deviated Septum Repair
- Foot Surgery
- Gallbladder Surgery
- Hysterectomy (Due to Cancer)
- Hysterectomy (Not Due to Cancer)
- Inguinal Hernia Surgery
- Kidney Stone Surgery
- Knee Surgery
- Mastectomy
- Ovarian Cyst Removal
- Prostate Surgery
- Shoulder Surgery
- Sinus Surgery
- Skin Biopsy
- Thyroid Surgery
- Tonsillectomy
- Tubal Ligation
- Vasectomy
- Weight Loss Surgery (Gastric Banding)
- Weight Loss Surgery (Gastric Bypass)
- Wrist Surgery

**OTHER** (please specify):

_____

Print in Color or Grayscale Only
Using Adobe Acrobat Reader 8.0 or later

# Patient Medical History
## Age 13 and older

**STAFF:** Responses in boxes and handwritten items must be entered **MANUALLY**.

## FAMILY MEDICAL HISTORY

**Please indicate which family member(s) have had these illnesses:**

- MOTHER'S Family History Unknown
- FATHER'S Family History Unknown
- Adopted

| | NO Family Member has had this illness | Mother | Father | MOTHER'S SIDE: Grandmother | MOTHER'S SIDE: Grandfather | MOTHER'S SIDE: Aunt | MOTHER'S SIDE: Uncle | FATHER'S SIDE: Grandmother | FATHER'S SIDE: Grandfather | FATHER'S SIDE: Aunt | FATHER'S SIDE: Uncle | Brother (1) | Brother (2) | Brother (3) | Sister (1) | Sister (2) | Sister (3) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Family Member Deceased | | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| ADD or ADHD | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Alcohol Abuse | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Anxiety | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Arthritis | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Asthma | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Bipolar Disorder | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Bleeding Disorder | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Blood Clots | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Breast Cancer (Before 50) | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Breast Cancer (After 50) | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Colon Cancer (Before 60) | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Colon Cancer (After 60) | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| COPD / Emphysema | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Coronary Artery Disease (Before 50) | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Depression | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Diabetes Type 1 (Juvenile) | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Diabetes Type 2 (Adult) | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Drug Abuse (IV / Intravenous) | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Drug Abuse (Narcotics / Opiates) | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| High Blood Pressure | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| High Cholesterol | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Hypothyroidism (Low Thyroid) | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Migraines | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Osteoporosis | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Ovarian Cancer | ○ | ○ | | ○ | | ○ | | ○ | | ○ | | | | | ○ | ○ | ○ |
| Prostate Cancer | ○ | | ○ | | ○ | | ○ | | ○ | | ○ | ○ | ○ | ○ | | | |
| Seizures / Convulsions | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Stroke / CVA of the Brain | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Sudden Cardiac Death | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Suicide - Attempt | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Suicide - Died | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Tuberculosis (TB) | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| Positive TB Skin Test | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |

**OTHER** (please specify condition and family member):

## NUTRITION

How would you describe your diet? (Mark all that apply.)

| | | |
|---|---|---|
| mixed diet ○ | low fat ○ | vegan (no animal products) ○ |
| diabetic diet ○ | lactose free ○ | vegetarian ○ |
| weight loss diet ○ | gluten free ○ | vegetarian + fish ○ |
| weight gain diet ○ | macrobiotic ○ | vegetarian + eggs + dairy ○ |
| kosher ○ | no red meat ○ | vegetarian + eggs + dairy + chicken ○ |

Do you drink caffeinated beverages? yes ○ no ○

If yes, how many per day: occasionally ○ 1-2 ○ 3-4 ○ 5-6 ○ 7+ ○

Do you drink any sweetened teas, sodas or sports drinks? yes ○ no ○

If yes, how many per day: occasionally ○ 1-2 ○ 3-4 ○ 5-6 ○ 7+ ○

Do you eat fruits and/or vegetables? yes ○ no ○

If yes, how many per day: occasionally ○ 1-2 ○ 3-4 ○ 5-6 ○ 7+ ○

Print in Color or Grayscale Only
Using Adobe Acrobat Reader 8.0 or later

# Patient Medical History
## Age 13 and older

STAFF: Responses in boxes and handwritten items must be entered MANUALLY.

## MALE PREVENTATIVE HEALTH (Men Only)

Do you perform monthly testicular self exams? yes ◯ no ◯

Do you use condoms when sexually active? always ◯ sometimes ◯ never ◯

## OB/GYN HISTORY (Women Only)

| | n/a | under 8 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21+ |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Age at onset of menstruation: | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |

| | n/a | under 42 | 42 | 43 | 44 | 45 | 46 | 47 | 48 | 49 | 50 | 51 | 52 | 53 | 54 | 55+ |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Age at onset of menopause: | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |

Please write in the start date of your last menstrual period: month / day / year

| PREGNANCY HISTORY | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7+ |
|---|---|---|---|---|---|---|---|---|
| Number of pregnancies: | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| Number of live births: | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| Number of stillbirths: | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| Number of premature births: | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| Number of miscarriages (spontaneous abortion): | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| Number of abortions (elective): | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| Number of caesarean sections: | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |

Are you pregnant or possibly pregnant? yes ◯ no ◯

Are you currently using birth control? yes ◯ no ◯

| Method(s): | PAST | CURRENT | | PAST | CURRENT | |
|---|---|---|---|---|---|---|
| | ◯ | ◯ | abstinence | ◯ | ◯ | rhythm method |
| | ◯ | ◯ | condom | ◯ | ◯ | ring |
| | ◯ | ◯ | Implanon | ◯ | ◯ | patch |
| | ◯ | ◯ | injection | ◯ | ◯ | pill |
| | ◯ | ◯ | intrauterine device (IUD) | other (please specify): _____ | | |

## PREVENTATIVE HEALTH (Both Men and Women)

| Please indicate when you last had each of the applicable tests: | N/A | 1 year or less | 2 years ago | 3 years ago | 4 years ago | 5 years ago | 6 years ago | 7 years ago | 8 years ago | 9 years ago | 10+ years ago | RESULTS: Normal | Abnormal | Don't Know |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Bone Density / Dexa Scan | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| Cholesterol Profile | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| Colonoscopy | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| Dental Exam | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| Eye Exam | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| Mammogram | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| Pap Smear | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| Prostate Cancer Screening | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |
| Stool Hemoccult (blood in stool) | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ | ◯ |

## ALLERGIES

**Please mark all allergies that you have:**

Are you allergic to **adhesive tape**? yes ◯ no ◯

Are you allergic to **latex**? yes ◯ no ◯

### Medication Allergies

- ◯ **No Known MEDICATION Allergies**
- ◯ Amoxicillin
- ◯ Cephalosporins
- ◯ Codeine
- ◯ Demerol
- ◯ Erythromycin
- ◯ Hydrocodone
- ◯ Morphine
- ◯ Oxycodone
- ◯ Penicillin
- ◯ Sulfa
- ◯ Tetracycline
- ◯ Vicodin
- ◯ NSAIDs (aspirin, ibuprofen acetaminophen, etc.)

### Food Allergies

- ◯ **No Known FOOD Allergies**
- ◯ Eggs
- ◯ Fish
- ◯ Gluten
- ◯ Milk
- ◯ Nuts
- ◯ Peanuts
- ◯ Seafood
- ◯ Soy
- ◯ Wheat

### Environmental Allergies

- ◯ **No Known ENVIRONMENTAL Allergies**
- ◯ Bee Stings
- ◯ Dust Mites
- ◯ Ragweed
- ◯ Pollen

**OTHER** (please specify): _____