

AUM Student Health Services

Name Andrew Ackerman

Date of Birth 02/26/94

PAST/CURRENT PERSONAL MEDICAL HISTORY: Have YOU EVER had any of the following?

Heart/Lungs ☐ Asthma ☐ Heart Disease (<i>valve, vessel, rheumatic, etc.</i>) ☐ Heart Murmur ☐ High Blood Pressure ☐ High Cholesterol ☐ Pneumonia	Stomach/Bowel ☐ Celiac Disease ☐ Irritable Bowel Syndrome ☐ Stomach/Duodenal Ulcers ☒ Ulcerative Colitis/Crohn's ☐ Other Liver, Stomach, or Bowel Disease	Hematology/Oncology ☐ Anemia ☐ Bleeding Disorders ☐ Blood Clots/Clotting Disorders ☐ Cancer ☐ Radiation Therapy	Anesthesia History ☐ Difficult intubation ☐ Malignant hyperthermia ☐ Post Op Nausea or Vomiting (PONV) ☐ Pseudocholesterase Deficiency ☐ Spinal headache	STDs ☐ Chlamydia ☐ Genital Herpes ☐ Genital Warts ☐ Gonorrhea ☐ HPV ☐ Other STD
Endocrine ☐ Adrenal Disorders ☐ Diabetes ☐ Polycystic Ovary Syndrome (PCOS) ☐ Thyroid Disorder	Neurological ☐ Concussions ☐ Convulsions/Seizures ☐ Migraines/Severe Headaches ☐ Multiple Sclerosis ☐ Muscular Dystrophy ☐ Stroke/TIA	Orthopedics ☐ Arthritis ☐ Fractures/Broken Bones	Surgical History ☐ Appendectomy ☐ Adenoideclomy ☐ Ear Tubes ☐ Gallbladder Removal ☐ Knee ACL Repair L R ☐ Knee Arthroscopy L R ☐ Organ Transplant	OB/GYN History ☐ Endometriosis ☐ Pregnancies#:
Kidney ☐ Chronic Kidney or Bladder Disease ☐ Kidney Stones	Mental Health ☐ ADHD ☐ Alcohol Abuse ☐ Anorexia (<i>Eating Disorder</i>) ☐ Anxiety Disorder ☐ Bulimia (<i>Eating Disorder</i>) ☐ Depression ☐ Drug Dependency ☐ Other Mental Health Problems	☐ HIV Infection ☐ Infectious Mononucleosis ☐ Malaria ☐ Mumps ☐ Tuberculosis ☐ Typhoid Fever	☐ Knee ACL Repair L R ☐ Knee Arthroscopy L R ☐ Organ Transplant ☐ Ovarian Cyst Removal ☐ Splenectomy ☐ Tonsillectomy ☐ Weight Loss Surgery ☐ Other Prior Surgeries	Exercise History ☒ Lack of exercise ☐ Exercising regularly Moderate Exercising <i>Walking briskly, water aerobics, etc.</i> ☐ Less than 3 times per week ☐ 3 or more times per week Strenuous Exercising <i>Running, swimming laps, etc.</i> ☐ Less than 3 times per week ☐ 3 or more times per week
Ears/Eyes/Nose/Throat ☐ Chronic Sinus Infections ☐ Eye Disorders (<i>other than glasses or contacts</i>) ☐ Hearing Loss ☐ Nasal Allergies/Hayfever		Skin ☐ Eczema ☐ Psoriasis ☐ Hives		

☐ NO Significant Health Problems

☐ List Medications

Allergies

Have you ever had an allergic reaction? ☐ Yes ☒ No

Medication Allergies: _____

Food Allergies: _____

Other Allergies (latex, bee stings, etc.): _____

Other History

☐ Previous Hospitalizations _____

☐ OTHER Health Problems _____

Does YOUR IMMEDIATE FAMILY have any of the following?

☐ Adopted (Family history unknown)

	Mother	Father	Siblings	Grandparents
Alcoholism	No	No		
Blood Clots/Clotting Disorders	No	No		
Cancer				
Breast	No	No		
Colon	No	No		
Melanoma	No	No		
Other Cancers (List Type)	No	No		
Diabetes	No	No		
Drug Dependency	No	No		
Heart Disease	No	No		
High Blood Pressure	No	Yes		
High Cholesterol	No	No		
Mental Illness	No	No		
Stroke	No	No		
Sudden Cardiac Arrest (under age 50)	No	No		
Other (Please explain)	No	No		
Parent Deceased	No	No		

What is your gender?

- ☐ Female
☒ Male
☐ Transgender
☐ Other

What is your sexual orientation?

- ☒ Heterosexual (Straight)
☐ Gay or Lesbian
☐ Bisexual
☐ Other

Abuse History

As violence is a problem in many families, we ask these questions to ALL patients.

- Verbal Abuse ☐ Yes ☒ No
Physical Abuse ☐ Yes ☒ No
Sexual Abuse ☐ Yes ☒ No

Drug History

Do you take recreational drugs? ☐ Yes ☒ No

How much? _____ How often? _____ What type? Marijuana Cocaine Meth Heroin Spice Other _____

Sexual History

Sexually active? ☐ Yes ☐ No ☒ Not currently

Partners ☐ Male ☒ Female ☐ Both

Birth Control/Protection - Please circle:

Abstinence Birth Control Pills Cervical Cap Condom Diaphragm Implant Injection IUD Patch

Post-menopausal Rhythm Spermicide Sponge Surgical Vaginal Condom Withdrawal Other *see comments* None

Last Menstrual Cycle _____ Last PAP _____ Normal Abnormal (Circle)

Comments:

Tobacco Use History

- ☐ Current every day
☐ Current some days
☐ Former smoker
☐ Heavy tobacco smoker
☐ Light tobacco smoker
☒ Never smoker
☐ Passive smoker - never smoked

Please circle:

Type used: Cigarettes Pipe Cigars Hookah E-cigs Chew

Packs/day: 0.25 0.5 1 1.5 2 3

Years: 0.5 1 2 2 4 5 10

Alcohol Use History

- ☐ Current every day
☐ Current some days
☐ Former drinker
☐ Heavy drinker
☐ Social drinker
☒ Never drinks

Please circle:

Type used: Beer Wine Liquor

Drinks/day: 0.25 0.5 1 1.5 2 3 4 5

Years: 0.5 1 2 2 4 5 10