

CONFIDENTIAL MEDICAL HISTORY FORM
AUM Student Health Services

Name Jennifer Norton Date of Birth 12/26/93

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) ☐ Pseudocholinesterase 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 ☐ Adenoidectomy ☒ 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	☐ 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 Sitrenuous 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

Last Medications

Allergies

Have you ever had an allergic reaction? ☒ Yes ☐ No
 Medication Allergies: Amoxicillin (Hives), Latex (Rash)
 Food Allergies: _____
 Other Allergies (latex, bee stings, etc.): _____

Other History

☒ Previous Hospitalizations 1995 PE tubes, 2011 lung biopsy
☐ OTHER Health Problems CHEST Syndrome with Pulmonary Fibrosis, Reactive hypoglycemia

Does YOUR IMMEDIATE FAMILY have any of the following?

☐ Adopted (Family history unknown)

	Mother	Father	Siblings	Grandparents
Alcoholism				☒
Blood Clots/Clotting Disorders				
Cancer	Breast			
	Colon			
	Melanoma			
	Other Cancers (List Type)			<u>Cervical</u>
Diabetes				
Drug Dependency				
Heart Disease				
High Blood Pressure	☒			
High Cholesterol		☒		
Mental Illness				
Stroke		☒		
Sudden Cardiac Arrest (under age 50)				
Other (Please explain)				
Parent Deceased				

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 7/16/17 Last PAP Dec 2016 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 3 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 3 4 5 10