

**CONFIDENTIAL MEDICAL HISTORY FORM**  
AUM Student Health Services

Name Paige Hines Date of Birth 3/5/77  
PAST/CURRENT PERSONAL MEDICAL HISTORY: Have YOU EVER had any of the following?

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
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| <b>Heart/Lungs</b><br><input type="checkbox"/> Asthma<br><input type="checkbox"/> Heart Disease (valve, vessel, rheumatic, etc.)<br><input type="checkbox"/> Heart Murmur<br><input type="checkbox"/> High Blood Pressure<br><input type="checkbox"/> High Cholesterol<br><input type="checkbox"/> Pneumonia<br><br><b>Endocrine</b><br><input type="checkbox"/> Adrenal Disorders<br><input type="checkbox"/> Diabetes<br><input type="checkbox"/> Polycystic Ovary Syndrome (PCOS)<br><input type="checkbox"/> Thyroid Disorder<br><br><b>Kidney</b><br><input type="checkbox"/> Chronic Kidney or Bladder Disease<br><input type="checkbox"/> Kidney Stones<br><br><b>Ears/Eyes/Nose/Throat</b><br><input type="checkbox"/> Chronic Sinus Infections<br><input type="checkbox"/> Eye Disorders (other than glasses or contacts)<br><input type="checkbox"/> Hearing Loss<br><input checked="" type="checkbox"/> Nasal Allergies/Hayfever | <b>Stomach/Bowel</b><br><input type="checkbox"/> Celiac Disease<br><input type="checkbox"/> Irritable Bowel Syndrome<br><input type="checkbox"/> Stomach/Duodenal Ulcers<br><input type="checkbox"/> Ulcerative Colitis/Crohn's<br><input type="checkbox"/> Other Liver, Stomach, or Bowel Disease<br><br><b>Neurological</b><br><input type="checkbox"/> Concussions<br><input type="checkbox"/> Convulsions/Seizures<br><input checked="" type="checkbox"/> Migraines/Severe Headaches<br><input type="checkbox"/> Multiple Sclerosis<br><input type="checkbox"/> Muscular Dystrophy<br><input type="checkbox"/> Stroke/TIA<br><br><b>Mental Health</b><br><input checked="" type="checkbox"/> ADHD<br><input type="checkbox"/> Alcohol Abuse<br><input type="checkbox"/> Anorexia (Eating Disorder)<br><input type="checkbox"/> Anxiety Disorder<br><input type="checkbox"/> Bulimia (Eating Disorder)<br><input checked="" type="checkbox"/> Depression<br><input type="checkbox"/> Drug Dependency<br><input type="checkbox"/> Other Mental Health Problems | <b>Hematology/Oncology</b><br><input type="checkbox"/> Anemia<br><input type="checkbox"/> Bleeding Disorders<br><input type="checkbox"/> Blood Clots/Clotting Disorders<br><input type="checkbox"/> Cancer<br><input type="checkbox"/> Radiation Therapy<br><br><b>Orthopedics</b><br><input type="checkbox"/> Arthritis<br><input checked="" type="checkbox"/> Fractures/Broken Bones<br><br><b>Infectious Diseases</b><br><input checked="" type="checkbox"/> Chickenpox/Varicella<br><input type="checkbox"/> Hepatitis Type:<br><input type="checkbox"/> HIV Infection<br><input type="checkbox"/> Infectious Mononucleosis<br><input type="checkbox"/> Malaria<br><input type="checkbox"/> Mumps<br><input type="checkbox"/> Tuberculosis<br><input type="checkbox"/> Typhoid Fever<br><br><b>Skin</b><br><input checked="" type="checkbox"/> Eczema<br><input type="checkbox"/> Psoriasis<br><input type="checkbox"/> Hives | <b>Anesthesia History</b><br><input type="checkbox"/> Difficult intubation<br><input type="checkbox"/> Malignant hyperthermia<br><input type="checkbox"/> Post Op Nausea or Vomiting (PONV)<br><input type="checkbox"/> Pseudocholinesterase Deficiency<br><input type="checkbox"/> Spinal headache<br><br><b>Surgical History</b><br><input type="checkbox"/> Appendectomy<br><input type="checkbox"/> Adenoidectomy<br><input checked="" type="checkbox"/> Ear Tubes<br><input checked="" type="checkbox"/> Gallbladder Removal<br><input type="checkbox"/> Knee ACL Repair L R<br><input type="checkbox"/> Knee Arthroscopy L R<br><input type="checkbox"/> Organ Transplant<br><input type="checkbox"/> Ovarian Cyst Removal<br><input type="checkbox"/> Splenectomy<br><input checked="" type="checkbox"/> Tonsillectomy<br><input checked="" type="checkbox"/> Weight Loss Surgery<br><input checked="" type="checkbox"/> Other Prior Surgeries<br><u>Hysterectomy</u> | <b>STDs</b><br><input type="checkbox"/> Chlamydia<br><input type="checkbox"/> Genital Herpes<br><input type="checkbox"/> Genital Warts<br><input type="checkbox"/> Gonorrhea<br><input type="checkbox"/> HPV<br><input type="checkbox"/> Other STD<br><br><b>OB/GYN History</b><br><input type="checkbox"/> Endometriosis<br><input type="checkbox"/> Pregnancies #: <u>3</u><br><br><b>Exercise History</b><br><input checked="" type="checkbox"/> Lack of exercise<br><input type="checkbox"/> Exercising regularly<br>Moderate Exercising<br><u>Walking briskly, water aerobics, etc.</u><br><input checked="" type="checkbox"/> Less than 3 times per week<br><input type="checkbox"/> 3 or more times per week<br>Strenuous Exercising<br><u>Running, swimming laps, etc.</u><br><input type="checkbox"/> Less than 3 times per week<br><input type="checkbox"/> 3 or more times per week |
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☒ NO Significant Health Problems

List Medications

**Allergies**

Have you ever had an allergic reaction? ☒ Yes ☐ No  
 Medication Allergies: Penicillin & Sulfa  
 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                           |               | <u>father</u> |          |                    |
| Blood Clots/Clotting Disorders       |               |               |          |                    |
| Cancer                               |               |               |          |                    |
| Breast                               |               |               |          |                    |
| Colon                                |               |               |          |                    |
| Melanoma                             |               |               |          |                    |
| Other Cancers (List Type)            |               |               |          |                    |
| Diabetes                             | <u>Mother</u> |               |          |                    |
| Drug Dependency                      |               |               |          | <u>Grandmother</u> |
| Heart Disease                        |               | <u>father</u> |          |                    |
| High Blood Pressure                  |               |               |          |                    |
| High Cholesterol                     |               |               |          |                    |
| Mental Illness                       |               |               |          |                    |
| Stroke                               |               |               |          |                    |
| Sudden Cardiac Arrest (under age 50) |               |               |          |                    |
| Other (Please explain)               |               |               |          |                    |
| Parent Deceased                      |               |               |          |                    |