

CONFIDENTIAL MEDICAL HISTORY FORM
AUM Student Health Services

Name Jonathan D. Davis Date of Birth 2-8-17

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 #: <u>1</u>
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	Infectious Diseases ☐ Chickenpox/Varicella ☐ Hepatitis Type: ☐ HIV Infection ☐ Infectious Mononucleosis ☐ Malaria ☐ Mumps ☐ Tuberculosis ☐ Typhoid Fever	☒ Ovarian Cyst Removal ☐ Splenectomy ☐ Tonsillectomy ☐ Weight Loss Surgery ☒ Other Prior Surgeries <u>Partial Hysterectomy</u> <u>Sinus Surgery</u> <u>C-Section</u>	Exercise History ☐ Lack of exercise ☐ Exercising regularly Moderate Exercising Walking briskly, water aerobics, etc. ☐ Less than 3 times per week ☒ 3 or more times per week Strenuous Exercising Running, swimming laps, etc. ☐ 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: None

Food Allergies: _____

Other Allergies (latex, bee stings, etc.): Dust, Perfumes, Smoke

Other History

☒ Previous Hospitalizations

Vertigo

☐ OTHER Health Problems _____

Does **YOUR IMMEDIATE FAMILY** have any of the following?

☐ Adopted (Family history unknown)

	Mother	Father	Siblings	Grandparents
Alcoholism				
Blood Clots/Clotting Disorders				
Cancer				Grandmother
Breast				
Colon				
Melanoma				
Other Cancers (List type)				Grandmother
Diabetes			Sister	
Drug Dependency			Brother	
Heart Disease				
High Blood Pressure				
High Cholesterol				
Mental Illness				
Stroke				Grandmother
Sudden Cardiac Arrest (under age 50)				
Other (Please explain)				Leukemia, Grandfather
Parent Deceased				Grandmother

Date

2/13/98

ADOLESCENT/ADULT HEALTH HISTORY

Name

Jennifer Dyess

1. What is the reason for your visit today? Cut finger
2. Is there anything about you and your health that we need to know? Cannot take PNC Penicillin
- *3. List medicine, drugs, or food you are allergic to: Penicillin
- *4. List any medicines or drugs you take: _____

5. Have YOU or anyone in your family had any of the following: (circle)

heart disease

high blood pressure

stroke

diabetes/sugar

blood problem or disease

cancer

tuberculosis

birth defects

mental retardation

nerve or mental problems

asthma

died before age 50

other "family" disease

6. Have you ever been in the hospital? yes Why? Kidney infection, ovarian cyst
7. Have you ever had surgery? yes Why? ovarian cyst + C-Section
8. Have you ever had a serious accident? no
9. Have you had serious or recent problems with:

ears or throat

NO YES

cough

NO YES

kidneys

NO YES

gallbladder

NO YES

allergies

NO YES

thyroid

NO YES

weight loss

NO YES

liver

NO YES

lung infections

NO YES

skin problems

NO YES

ulcers

NO YES

depression

NO YES

headaches

NO YES

10. Have you ever had a seizure, convulsion, or "falling out" spell? NO YES

11. Have you ever had a blood clot in your lungs, legs or anywhere? NO YES

- *12. Have you ever smoked cigarettes or used smokeless tobacco? NO YES

If yes, are you an: Ex-smoker? Smoking now? Do you smoke (less) (more) than a pack a day?

How much smokeless tobacco do you use a day? _____

- *13. How often do you drink beer, wine, wine coolers, or liquor?

Never Rarely 1-2 times a week 3-4 times a week 5 or more times a week

If you drink beer, wine, wine coolers, or liquor, do you have:

(less) (more) than 5 drinks a day?

- *14. Have you ever used marijuana, cocaine, crack or other drugs? NO YES

- *15. Have you ever used I.V. drugs? NO YES

16. Have you ever had a blood transfusion? NO YES

17. Do you have any tattoos? NO YES

18. Have you ever been treated for a venereal disease? NO YES

19. Have you had more than one sex partner in the past 5 years? NO YES

20. Have you ever had sex with a member of your own sex? NO YES

21. Have you had or been around anyone with hepatitis? NO YES

22. Would your sex partner(s) answer Yes to any of the questions 14-22? NO YES

FOR FEMALES ONLY

- A. How old were you when you started your periods? 13 Date of your last period? 1-14-98

How often do you have your periods? once a month Are they regular? yes

How many days do they last? 4

Do you have: (circle) bad cramps bleeding or spotting between periods unusual discharge

- B. Do you have any problems with your breasts (lumps, discharge, or other)? NO YES

Do you check them regularly? YES NO

- *C. How many times have you ever been pregnant? 1 How many children are living? 1

Have you ever had any children born dead; any stillbirths, miscarriages, or abortions? NO YES

Were any of your children premature? NO YES

How old were you when your first child was born? 25

- D. Have you ever used: (circle NO/YES) birth control pills? NO YES; foam? NO YES; condoms? NO YES; IUD? NO YES;

diaphragm? NO YES

- E. Did you have problems with any of these methods? NO YES

- F. Have you ever had an abnormal PAP smear? NO YES