

NAME: Kelly Cox Date: 6/22/18

AUM Student Health Services Comprehensive Health History Form

Medical History: Do you have, or have you ever had any of the following? (check all that apply)

Cardiovascular ☐ High Blood Pressure ☐ Congestive Heart Failure ☐ Atrial Fibrillation ☐ Other: _____	Gastrointestinal ☐ Ulcers ☐ Pancreatitis ☐ Irritable Bowel ☐ Colitis ☐ Crohn's ☐ Reflux	Respiratory ☐ Asthma ☐ COPD / Emphysema ☐ TB (Tuberculosis)	Immunologic / Viral ☐ HIV / AIDS ☐ Herpes ☐ Epstein-Barr	Endocrine ☐ Diabetes ☐ Thyroid (Hyper/Hypo) Musculoskeletal ☐ Arthritis
Neurologic ☐ Stroke ☐ Parkinson's Disease ☐ Alzheimer's / Dementia ☒ Seizure Disorder ☐ Headaches ☒ Migraines ☐ Sleep Apnea ☐ Fibromyalgia ☐ Insomnia (Can't Sleep)	Kidney & Urologic ☐ Kidney Stones ☐ Enlarged Prostate ☐ Urinary Tract Infections Liver ☐ Gallstones ☐ Cirrhosis Hepatitis: ☐ A ☐ B ☐ C	Reproductive ☐ Hysterectomy ☐ Contraceptives Used: Menstrual Cycle: ☐ Regular ☐ Irregular ☐ Genital Disease(s) ☐ Infertility ☐ Erectile Dysfunction	Ear/Nose/Throat/Eye ☐ Glaucoma ☐ Cataract ☐ Chronic Sinus Infection ☐ Upper Airway Infections ☐ Dizziness	Other ☐ Cancer (explain): ☐ Anemia ☐ High Cholesterol ☐ Sickle Cell ☐ On Anticoagulants ☐ Chronic Pain (explain): ☐ Skin Conditions (explain):

Review of Systems: (check all SYMPTOMS that apply)

Systemic Weight: ☐ gain ☐ loss ☐ Fever ☐ Chills ☐ Night Sweats ☐ Pain	Gastrointestinal Appetite: ☐ good ☐ fair ☐ poor ☐ Difficulty Swallowing ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ Heartburn ☐ Rectal Bleeding ☐ Abdominal Pain	Cardiovascular ☐ Chest Pain ☐ Palpitations (irregular heartbeat)	Skin ☐ Dry Skin ☒ Itchy Skin ☐ Peeling Skin ☐ Scaling Skin ☐ Discolored Skin ☒ Rash(es) on Skin	Endocrine ☐ Excessive Thirst ☐ Heat Intolerance ☐ Cold Intolerance ☐ Excessive Sweating ☐ Feelings of Weakness
Neurologic / Head ☐ Involuntary Movements ☐ Speech Problems ☐ Paralysis ☐ Dizziness ☐ Fainting ☐ Vertigo ☐ Confusion ☐ Memory Loss ☐ Limb Weakness ☐ Balance Problems ☐ Tingling ☐ Numbness ☐ Headache ☐ Sinus Pain	Genitourinary ☐ Blood in Urine ☐ Odor in Urine ☐ Frequent Urination ☐ Difficult Urination ☐ Small Amount of Urine ☐ Night Time Urination ☐ Incontinent of Urine	Pulmonary ☐ Difficulty Breathing ☐ Short of Breath ☐ Dry Cough ☐ Productive Cough ☐ Cough with Blood ☐ Wheezing	Eye and Ears-Nose-Throat ☐ Vision ☐ Diplopia ☐ Blurry Vision ☐ Red Eyes ☐ Hearing Loss ☐ Tinnitus (ringing in ear) ☐ Epistaxis (nose bleeds) ☐ Nasal Itching ☐ Sore Throat ☐ Mouth Sores ☐ Mouth Dryness ☐ Runny Nose	Musculoskeletal ☐ Back Pain ☐ Muscle Aches ☐ Muscle Cramps ☐ Joint Pain - localized ☐ Joint Swelling - localized ☐ Joint Stiffness - localized ☐ Arthritis Pain

Please list all prior surgeries and hospitalizations for medical illnesses:

Do you have any allergies to food or medications? If so, please list below & the type(s) of reaction (ie: hives, tongue swelling, etc.).

no known allergies

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FAMILY HISTORY: *Indicate illnesses in blood relatives. Check those that apply.*

- | | | |
|--|---|---|
| ☐ Anemia | ☐ Diabetes (type 1 or 2) | ☐ Migraines/headaches |
| ☐ Bleeding or clotting abnormally | ☒ Heart disease | ☒ Stroke |
| ☐ Breast disease | ☐ High cholesterol | ☐ Thyroid disorder (Hypo or Hyper) |
| ☐ Cancer | ☒ High blood pressure | ☒ Arthritis |
| ☐ Prostate | | ☐ Rheumatoid |
| ☐ Skin | | ☐ Osteoarthritis |
| ☐ Colon | | |
| ☐ Lung | | ☐ Connective Tissue |
| ☐ Breast | | ☐ Lupus |
| ☐ Other _____ | | Other: _____ |

Pharmacy Information:

Please List all current medications below

(include birth control pills, over the counter medication and herbal remedies (i.e. decongestants, St. John's Wort etc.)

Name of Medication	Dosage (Mg)	Times per Day	Dates of Use	Side Effects (if any)	Prescribing Physician

Preferred pharmacy? Publix @ Taylor Junction Phone #: _____

For Women:

GYNECOLOGICAL HISTORY:

Do you a period every month? ☒ Yes ☐ No

Number of days of flow: 4

Menstrual cramps: ☒ mild ☒ moderate ☐ severe ☐ normal

Date of last PAP smear: _____ Last PAP smear results: _____ Have you ever had an abnormal Pap smears? ☐ Yes ☒ No

If yes, explain clinical history (including test location, date, what was done) for any abnormal PAP smear?

Are you presently trying to become pregnant or will be trying soon? ☐ Yes ☒ No

Have you had a mammogram? ☐ Yes ☒ No

If applicable, indicate the date and result of your last mammogram: