

Confidential Medical History Form

AUM Student Health Services

Name Leahne Broedue Law Date of Birth 10-24-17

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	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 ☐ Ovarian Cyst Removal ☐ Splenectomy ☐ Tonsillectomy ☐ Weight Loss Surgery ☐ Other Prior Surgeries	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	Infectious Diseases ☐ Chickenpox/Varicella ☐ Hepatitis Type: ☐ HIV Infection ☐ Infectious Mononucleosis ☐ Malaria ☐ Mumps ☐ Tuberculosis ☐ Typhoid Fever	☒ 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				
Blood Clots/Clotting Disorders				
Cancer	Breast			
	Colon			
	Melanoma			
	Other Cancers (List type)		Prostate	
Diabetes				✓
Drug Dependency				
Heart Disease	✓			
High Blood Pressure			✓	
High Cholesterol			✓	
Mental Illness				✓
Stroke				
Sudden Cardiac Arrest (under age 50)				
Other (Please explain)				
Parent Deceased				

AUM Student Health Services
Medical Information Release Form
(HIPAA Release Form)

Name: Jeanine Boddie Lova Date of Birth: 10/24/17

Release of Information

☒ I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

☐ Spouse Divonne Lova

☐ Child(ren) _____

☐ Other _____

☐ Information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

Messages

Please call ☐ my home ☒ my work ☒ my cell Number: 244-3639 / 312 6954

If unable to reach me:

☐ you may leave a detailed message

☒ please leave a message asking me to return your call

☐ _____

The best time to reach me is (day) 8-5 Day between (time) _____

Signed: Jeanine Boddie Lova Date: 10/24/17