

Confidential Medical History Form

AUM Student Health Services

Name Ashley L. Cochran Date of Birth 12-19-87

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	☐ Knee ACL Repair L R ☐ Knee Arthroscopy L R ☐ Organ Transplant ☐ Ovarian Cyst Removal ☐ Splenectomy ☐ Tonsillectomy ☐ Weight Loss Surgery ☒ Other Prior Surgeries <u>C-section</u>	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 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	☐ Kidney Stones ☒ Anxiety Disorder ☐ Bulimia (<i>Eating Disorder</i>) ☒ Depression ☐ Drug Dependency ☐ Other Mental Health Problems	Skin ☐ Eczema ☐ Psoriasis ☐ Hives		

☒ NO Significant Health Problems

List Medications: Celebra Birth control, vitamin

Allergies

Have you ever had an allergic reaction? ☐ Yes ☒ No

Medication Allergies: none

Food Allergies: none

Other Allergies (latex, bee stings, etc.): ADHD, seasonal, cats

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>yes</u>
Blood Clots/Clotting Disorders				
Cancer	Breast			
	Colon			
	Melanoma			
	Other Cancers (List Type)			<u>X</u>
Diabetes		<u>X</u>		
Drug Dependency				
Heart Disease				
High Blood Pressure		<u>X</u>		
High Cholesterol	<u>X</u>			
Mental Illness				
Stroke				<u>X</u>
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 Sept. 27, 2017 Last PAP Nov. 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 2 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 2 4 5 10