

AUM Student Health Services

Name Tina Berry Date of Birth _____

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>2</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>Tubes tied / 2010</u> <u>Tubal Reversal / 2016</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				

☒ 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	X	^		
Blood Clots/Clotting Disorders				
Cancer	Breast			
	Colon			
	Melanoma			
	Other Cancers (List type)			
Diabetes				
Drug Dependency				
Heart Disease				
High Blood Pressure		X		
High Cholesterol				
Mental Illness				
Stroke				
Sudden Cardiac Arrest (under age 50)				
Other (Please explain)				
Parent Deceased		X		