

AUM NURSING CARE CENTER
ADOLESCENT/ADULT HEALTH HISTORY

Date 01/5/2018

Name YARLAGADDA, SREE VYSHNAVI

1. What is the reason for your visit today? TR SKIN TEST
 2. Is there anything about you and your health that we need to know? NO
 - *3. List medicine, drugs, or food you are allergic to: NO
 - *4. List any medicines or drugs you take: NO
 5. Have YOU or anyone in your family had any of the following: (circle)
- | | | | |
|---------------------|--|--------------------|--------------------------|
| heart disease | diabetes/sugar ☒ | tuberculosis | nerve or mental problems |
| high blood pressure | blood problem or disease | birth defects | asthma |
| stroke | cancer | mental retardation | died before age 50 |
| | | | other "family" disease |
6. Have you ever been in the hospital? NO Why? NO
 7. Have you ever had surgery? NO Why? NO
 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
 11. Have you ever had a blood clot in your lungs, legs or anywhere? NO
 - *12. Have you ever smoked cigarettes or used smokeless tobacco? NO
 - 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? NEVER
 - *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
 - *15. Have you ever used I.V. drugs? NO
 16. Have you ever had a blood transfusion? NO
 17. Do you have any tattoos? NO
 18. Have you ever been treated for a venereal disease? NO
 19. Have you had more than one sex partner in the past 5 years? NO
 20. Have you ever had sex with a member of your own sex? NO
 21. Have you had or been around anyone with hepatitis? NO
 22. Would your sex partner(s) answer Yes to any of the questions 14-22? NO

FOR FEMALES ONLY

- A. How old were you when you started your periods? 12 Date of your last period? 15th
- How often do you have your periods? 1 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? 0 How many children are living? 0
- 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? 15
- 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