

NAME: SAT JYOTHIRMAI GULLIPALLI

Family History: Have **YOU** or anyone in your family ever been treated for any of the following?

	You	Father	Mother	Aunt	Uncle	Brother	Sister	Children	Grandparent	Other
Depression										
Anxiety										
Panic Attacks										
Post-traumatic stress										
Bipolar										
Schizophrenia										
Alcohol/Drug problems										
ADHD/ADD										
Suicide attempts										
Suicide										

☒ Check here if there is no known family history

Substance Abuse History

Regarding alcohol, when was your last drink?

In the past 30 days, about how many of those days have you had at least one alcoholic drink?

What is the maximum number of drinks you have had in one day in the past month?

Have you ever experienced the following? DUI DWI Public Intoxication Seizures DT's

Please check the appropriate boxes that apply to you for the following substances:

	Never Used	Age first used	Last used on this date (approximately)	Age peak use	History of abuse	Current use and frequency
Cocaine	✓					
Amphetamine or Speed	✓					
Marijuana	✓					
Pain Pills			2 weeks back			
Cigarettes, Cigars or Tobacco		✓				
Heroin	✓					
Benzodiazepines (Xanax, Valium, Ativan, Restoril, Librium)	✓					
Other:						

Pharmacy Name and Number

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? _____ Phone #: _____

NAME: _____

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: _____ |

SEXUAL HISTORY:

Have you ever been sexually active? __Yes __No

Are you currently sexually active? __Yes __No

Do you use protection and or contraceptives? __Yes __No

- | | | |
|--|-----------------------------------|---------------------------------------|
| ☐ birth control pills | ☐ IUD | ☐ Condoms |
| ☐ DepoProvera | ☐ Implants | ☐ Other: _____ |

Complete the following questions if you are sexually active:

Are you currently having sexual relations with one partner or multiple partners? __one __multiple

Number of partners in last year: _____

Are/Is your sexual partner(s): __ men __ women __ both

Have you ever had a sexually transmitted infection (STI)(ie: HPV, Herpes, Chlamydia, Gonorrhea or other)? __ Yes __No

List STI: _____ Treated: __ Yes __ No

GYNECOLOGICAL HISTORY:

Do you a period every month? __Yes __No

Number of days of flow: _____

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:

Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME _____

DATE OF BIRTH _____ / _____ / _____
month day year

For patients: The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	yes	no	don't know
1. Are you sick today?	☐	☒	☐
2. Do you have allergies to medications, food, a vaccine component, or latex?	☐	☒	☒
3. Have you ever had a serious reaction after receiving a vaccination?	☐	☒	☐
4. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder?	☐	☒	☐
5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☒	☐
6. In the past 3 months, have you taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments?	☐	☒	☐
7. Have you had a seizure or a brain or other nervous system problem?	☐	☒	☐
8. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☒	☐
9. For women: Are you pregnant or is there a chance you could become pregnant during the next month?	☐	☒	☐
10. Have you received any vaccinations in the past 4 weeks?	☐	☒	☐

FORM COMPLETED BY _____ DATE 2/9/2018

FORM REVIEWED BY _____ DATE _____

Did you bring your immunization record card with you? yes ☒ no ☐

It is important for you to have a personal record of your vaccinations. If you don't have a personal record, ask your healthcare provider to give you one. Keep this record in a safe place and bring it with you every time you seek medical care. Make sure your healthcare provider records all your vaccinations on it.

NAME: _____

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:

None

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

None