

NAME:

Sean Spencer

Date:

2/21/18**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:

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

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2/21/18**FAMILY HISTORY:** Indicate illnesses in blood relatives. Check those that apply.

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|--|--|---|
| ☐ 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 ___ NoAre you currently sexually active? ☒ Yes ___ NoDo 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 ☒ multipleNumber of partners in last year: 6Are/Is your sexual partner(s): ___ men ☒ women ___ bothHave you ever had a sexually transmitted infection (STI)(ie: HPV, Herpes, Chlamydia, Gonorrhea or other)? ☒ Yes ___ NoList STI: Chlamydia 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:

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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? Don't drink none none no 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						
Cigarettes, Cigars or Tobacco						
Heroin						
Benzodiazepines (Xanax, Valium, Ativan, Restoril, Librium)						
Other:						

Pharmacy Name and NumberPlease 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? Walmart

Phone #: