

NAME: Kristen KillcreaseDate: 2/28/18**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)
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	Musculoskeletal ☐ Arthritis
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:

gallbladder removal
 appendicitis
 wpm ablation
 miscarriage / D&C

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

Sulfur - heart racing

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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	X	X					X		X	
Anxiety	X	X					X		X	
Panic Attacks	X	X					X			
Post-traumatic stress							X			
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? n/a

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

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

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	X					
Amphetamine or Speed	X					
Marijuana	X					
Pain Pills	X					
Cigarettes, Cigars or Tobacco	X					
Heroin	X					
Benzodiazepines (Xanax, Valium, Ativan, Restoril, Librium)	X					
Other:	X					

Pharmacy Name and Number ~~Public Health and Safety~~ Adams Drugs
Copperfield

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
<u>Lexapro</u>	<u>20mg</u>	<u>1</u>	<u>daily</u>		<u>Needham</u>
<u>Zyrtec</u>	<u>10K</u>	<u>1</u>	<u>as needed</u>		
<u>prenatal</u>	<u>1</u>	<u>1</u>	<u>daily</u>		

Preferred pharmacy? Adams Copperfield Phone #: 386-9370

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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 X No

Number of days of flow: varies

Menstrual cramps: __ mild __ moderate __ severe __ normal varies

Date of last PAP smear: 8/1/12 Last PAP smear results: _____ Have you ever had an abnormal Pap smears? __Yes X 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? X Yes __ No

Have you had a mammogram? __Yes X No

If applicable, indicate the date and result of your last mammogram: