

NAME: Abdullah Aljohani Date: 6/3/2018

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: 1

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:

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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.).

No

NAME: Abdullah AljohaniDate: 6/3/2018Family 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? Never

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						✓
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
INDERAL	40	1	2 months		
IPRAMAX	25	1	2 months		
SOLPADEINE	500	1-2	4 years		

Preferred pharmacy? _____ Phone #: _____