

Commercial Medical History Form
AUM Student Health Services

Name Paula Diaz Date of Birth _____

PAST/CURRENT PERSONAL MEDICAL HISTORY: Have YOU EVER had any of the following?

Heart/Lungs ☐ Asthma ☐ Heart Disease (<i>valve, vessel, rheumatic, etc.</i>) ☐ Heart Murmur ☐ High Blood Pressure ☐ High Cholesterol ☐ Pneumonia	Stomach/Bowel ☐ Celiac Disease ☐ Irritable Bowel Syndrome ☐ Stomach/Duodenal Ulcers ☐ Ulcerative Colitis/Crohn's ☐ Other Liver, Stomach, or Bowel Disease	Hematology/Oncology ☐ Anemia ☐ Bleeding Disorders ☐ Blood Clots/Clotting Disorders ☐ Cancer ☐ Radiation Therapy	Anesthesia History ☐ Difficult intubation ☐ Malignant hyperthermia ☐ Post Op Nausea or Vomiting (PONV) ☐ Pseudocholinesterase Deficiency ☐ Spinal headache	STDs ☐ Chlamydia ☐ Genital Herpes ☐ Genital Warts ☐ Gonorrhea ☐ HPV ☐ Other STD
Endocrine ☐ Adrenal Disorders ☐ Diabetes ☐ Polycystic Ovary Syndrome (PCOS) ☐ Thyroid Disorder	Neurological ☐ Concussions ☐ Convulsions/Seizures ☐ Migraines/Severe Headaches ☐ Multiple Sclerosis ☐ Muscular Dystrophy ☐ Stroke/TIA	Orthopedics ☐ Arthritis ☐ Fractures/Broken Bones	Surgical History ☐ Appendectomy ☐ Adenoidectomy ☐ Ear Tubes ☐ Gallbladder Removal ☐ Knee ACL Repair L R ☐ Knee Arthroscopy L R ☐ Organ Transplant	OB/GYN History ☐ Endometriosis ☐ Pregnancies #: _____
Kidney ☐ Chronic Kidney or Bladder Disease ☐ Kidney Stones	Mental Health ☐ ADHD ☐ Alcohol Abuse ☐ Anorexia (<i>Eating Disorder</i>) ☐ Anxiety Disorder ☐ Bulimia (<i>Eating Disorder</i>) ☐ Depression ☐ Drug Dependency ☐ Other Mental Health Problems	Infectious Diseases ☐ Chickenpox/Varicella ☒ Hepatitis Type: <u>A</u> ☐ HIV Infection ☐ Infectious Mononucleosis ☐ Malaria ☐ Mumps ☐ Tuberculosis ☐ Typhoid Fever	☐ Ovarian Cyst Removal ☐ Splenectomy ☐ Tonsillectomy ☐ Weight Loss Surgery ☐ Other Prior Surgeries	Exercise History ☐ Lack of exercise ☒ Exercising regularly Moderate Exercising <i>Walking briskly, water aerobics, etc.</i> ☐ Less than 3 times per week ☒ 3 or more times per week Strenuous Exercising <i>Running, swimming laps, etc.</i> ☐ Less than 3 times per week ☒ 3 or more times per week
Ears/Eyes/Nose/Throat ☐ Chronic Sinus Infections ☐ Eye Disorders (<i>other than glasses or contacts</i>) ☐ Hearing Loss ☐ Nasal Allergies/Hayfever		Skin ☐ Eczema ☐ Psoriasis ☐ Hives		

☐ NO Significant Health Problems

List Medications _____

Allergies

Have you ever had an allergic reaction? ☐ Yes ☒ No

Medication Allergies: _____

Food Allergies: _____

Other Allergies (latex, bee stings, etc.): _____

Other History

☐ Previous Hospitalizations foot surgery

☐ OTHER Health Problems _____

Does YOUR IMMEDIATE FAMILY have any of the following?

☐ Adopted (Family history unknown)

	Mother	Father	Siblings	Grandparents
Alcoholism				
Blood Clots/Clotting Disorders				
Cancer				
Breast				
Colon				
Melanoma				
Other Cancers (List type)				<u>My grandfather</u>
Diabetes				
Drug Dependency				
Heart Disease				
High Blood Pressure				
High Cholesterol				
Mental Illness				
Stroke				
Sudden Cardiac Arrest (under age 50)				
Other (Please explain)				
Parent Deceased				

What is your gender?

- ☒ Female
☐ Male
☐ Transgender
☐ Other

What is your sexual orientation?

- ☒ Heterosexual (Straight)
☐ Gay or Lesbian
☐ Bisexual
☐ Other

Abuse History

As violence is a problem in many families, we ask these questions to ALL patients.

- Verbal Abuse ☐ Yes ☒ No
 Physical Abuse ☐ Yes ☒ No
 Sexual Abuse ☐ Yes ☒ No

Drug History

Do you take recreational drugs? ☐ Yes ☒ No

How much? _____ How often? _____ What type? Marijuana Cocaine Meth Heroin Spice Other _____

Sexual History

Sexually active? ☒ Yes ☐ No ☐ Not currently

Partners ☒ Male ☐ Female ☐ Both

Birth Control/Protection - Please circle:

Abstinence Birth Control Pills Cervical Cap Condom Diaphragm Implant Injection IUD Patch

Post-menopausal Rhythm Spermicide Sponge Surgical Vaginal Condom Withdrawal Other see comments None

Last Menstrual Cycle March 17th Last PAP Never had one Normal Abnormal (Circle)

Comments:

Tobacco Use History

- ☐ Current every day
☐ Current some days
☐ Former smoker
☐ Heavy tobacco smoker
☐ Light tobacco smoker
☒ Never smoker
☐ Passive smoker - never smoked

Please circle:

Type used: Cigarettes Pipe Cigars Hookah E-cigs Chew

Packs/day: 0.25 0.5 1 1.5 2 3

Years: 0.5 1 2 4 5 10

Alcohol Use History

- ☐ Current every day
☐ Current some days
☐ Former drinker
☐ Heavy drinker
☐ Social drinker
☒ Never drinks

Please circle:

Type used: Beer Wine Liquor

Drinks/day: 0.25 0.5 1 1.5 2 3 4 5

Years: 0.5 1 2 4 5 10

AUM NURSING CARE CENTER
ADOLESCENT/ADULT HEALTH HISTO.

Date 08/21/2013

Name Paula Diaz

1. What is the reason for your visit today? TB 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: Nothing
 *4. List any medicines or drugs you take: Nothing

5. Have YOU or anyone in your family had any of the following: (circle)

heart disease
high blood pressure
stroke

diabetes/sugar
blood problem or disease
cancer

tuberculosis
birth defects
mental retardation

nerve or mental problems
asthma
died before age 50
other "family" disease

6. Have you ever been in the hospital? yes Why? surgery
 7. Have you ever had surgery? yes Why? in my feet
 8. Have you ever had a serious accident? NO
 9. Have you had serious or recent problems with:

ears or throat ☒ NO YES
 allergies ☒ NO YES
 lung infections ☒ NO YES

cough ☒ NO YES
 thyroid ☒ NO YES
 skin problems ☒ NO YES

kidneys ☒ NO YES
 weight loss ☒ NO YES
 ulcers ☒ NO YES

gallbladder ☒ NO YES
 liver ☒ NO YES
 depression ☒ NO YES
 headaches ☒ NO YES

10. Have you ever had a seizure, convulsion, or "falling out" spell? ☒ NO YES
 11. Have you ever had a blood clot in your lungs, legs or anywhere? ☒ NO YES
 *12. Have you ever smoked cigarettes or used smokeless tobacco? ☒ NO YES

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?

- *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 YES
 *15. Have you ever used I.V. drugs? ☒ NO YES
 16. Have you ever had a blood transfusion? ☒ NO YES
 17. Do you have any tattoos? ☒ NO YES
 18. Have you ever been treated for a venereal disease? ☒ NO YES
 19. Have you had more than one sex partner in the past 5 years? ☒ NO YES
 20. Have you ever had sex with a member of your own sex? ☒ NO YES
 21. Have you had or been around anyone with hepatitis? ☒ NO YES
 22. Would your sex partner(s) answer Yes to any of the questions 14-22? ☒ NO YES

FOR FEMALES ONLY

- A. How old were you when you started your periods? 12 Date of your last period? 08/21/2013
 How often do you have your periods? every month Are they regular? yes
 How many days do they last? 7
 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? _____
 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? _____
 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