

Allergies _____

SPRING 2010

Student ID _____ **Last Name** _____ **First Name** _____ **MI** _____ **Maiden** _____

Marital Status: Single Married Widowed Divorced Other _____ **Alcohol EDU** ___Y ___N

Ethnic Origin _____ **E-Mail Address** _____ **Birthdate** _____

Local Address: Street _____ Apartment Number _____ City _____ State _____ Zip _____

Local Phone _____ Work Phone _____ Parent's Phone _____ Insurance Company _____

Please check (✓) **Give dates when known:** **Medications you currently take:** _____

TB _____ Results _____ Measles _____

Tetanus _____ MMR _____ Mumps _____

Hepatitis A _____ Rubella _____

Hepatitis B _____ Chicken Pox _____ **Have you ever :**

Meningitis _____ **Had a blood transfusion** Y / N **Had unprotected sex** Y / N

Do you use tobacco Y / N **# of years** _____ **Been an IV drug user** Y / N **Sex with an IV drug user** Y / N

Type _____ **Amt/day** _____ **Abused other drugs** Y / N **Had Hepatitis** Y / N

Do you drink alcohol Y / N **# of years** _____ **Used recreational (street) drugs?** _____ **Type** A B C

Have you ever been sexually active Y / N **Amt/day** _____ **List Kinds:** _____ **Date of last use:** _____

Age of first vaginal intercourse _____

Menstrual history

Period: regular irregular **Hysterectomy?** ___ date ___ **# of children** _____ **# of abortions** _____

Flow: Light Moderate Excessive **Last Pap Smear** _____ **# of pregnancies** _____ **# of miscarriages** _____

Duration (# of days) _____ **History of Abnormal Pap** _____ **Never had Pap**

Age when had first period: _____ Do you have cramps with your period? _____ What treatment do you use for your cramps? _____	Do you have pre-menstrual symptoms? _____ Including: weight gain: ___ increased appetite: ___ depression: ___ Fatigue: ___ breast tenderness: ___ Headache: ___ irritability: ___, other: _____
---	--

	Self	Father	Mother	Brother/ sister	Grand- parents		Self	Father	Mother	Brother/ sister	Grand- parents
Alive						Heart Disease					
Cause of Death						Epilepsy					
Age of Death						Diabetes					
Mental Depression						Cancer					
Breast Disease/cancer						Asthma					
Hyperlipidemia (High cholesterol)						Hay Fever					
Thyroid problems						Arthritis					
Gall Bladder problems						Kidney Disease					
Phlebitis						Glaucoma					
Hepatitis						Stroke					
High Blood Pressure						Migraine					

Are you having any of the following now? Please check the box on the left side of the list:

- | | | |
|---|--|---|
| <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Blurred vision, double vision | <input type="checkbox"/> Concerns about sexually transmitted diseases |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Weight changes | <input type="checkbox"/> Varicose veins |
| <input type="checkbox"/> Lumps in breast | <input type="checkbox"/> Phlebitis or clots in veins | <input type="checkbox"/> Crying spells |
| <input type="checkbox"/> Loss of urine | <input type="checkbox"/> School or social problems | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Pain or swelling in legs | | |

If you have ever had or still have any of the following, please describe, including date of onset, treatment, etc. Please place a check mark on the line on the extreme left side if you answer is yes.

✓		Date of Onset, Treatment, other Details	✓		Date of Onset, Treatment, other Details
	Rheumatic fever			Heart murmur	
	Nervous trouble			Cancer	
	High blood pressure			Stroke	
	Thyroid trouble			Sickle cell anemia or trait	
	Hepatitis or liver problems			Migraine Headache	
	Tonsillitis			Ulcers	
	Vaginal infection, discharge, or sores			Abnormal Pap smear	
	Sexually transmitted disease including warts (HPV), AIDS			Pelvic inflammatory disease or ovary/uterus/tube problem	
	Severe injuries			Urinary tract infection or pain, frequency, or burning on urination	
	Surgeries			Any other illness not listed	

Sexual Activity and Birth Control

Douches: _____ deodorant tampons: _____, feminine hygiene sprays: _____
 Date of last pelvic (internal) exam: _____ Never had exam: _____
 Are you having sexual relations now? _____ How often? _____
 Have you been sexually active in the past? _____ Number of partners (lifetime): _____
 Your sexual preference: male _____ female _____ both _____
 Do you have pain during or after sexual relations? _____
 If you have a male partner, are you using any birth control method? _____
 If yes which one(s) and for how long? _____
 Does your partner use condoms? _____ If yes, how often? _____
 Are you satisfied with your present method? _____ Have you ever had a problem, including pregnancy, with a birth control method? _____ if yes, explain _____

List in order of use methods of birth control

	Method	Dates of Use	Problems or Comments
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

Have you ever been sexually molested / assaulted / harassed or been a victim of incest? _____
 Is there violence in any of your relationships? _____ Are you afraid of your partner? _____

Signature _____ Date _____

History Reviewed:

Signature _____	Date _____	Signature _____	Date _____
Signature _____	Date _____	Signature _____	Date _____