Confidential Medical History Form

Name _____ Date of Birth _____

Hometown _____ Major _____

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

Heart/Lungs
- ☐ Asthma
- ☐ Heart Disease *(valve, vessel, rheumatic, etc.)*
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Pneumonia

Endocrine
- ☐ Adrenal Disorders
- ☐ Diabetes
- ☐ Polycystic Ovary Syndrome (PCOS)
- ☐ Thyroid Disorder

Kidney
- ☐ Chronic Kidney or Bladder Disease
- ☐ Kidney Stones

Ears/Eyes/Nose/Throat
- ☐ Chronic Sinus Infections
- ☐ Eye Disorders *(other than glasses or contacts)*
- ☐ Hearing Loss
- ☐ Nasal Allergies/Hayfever

Stomach/Bowel
- ☐ Celiac Disease
- ☐ Irritable Bowel Syndrome
- ☐ Stomach/Duodenal Ulcers
- ☐ Ulcerative Colitis/Crohn's
- ☐ Other Liver, Stomach, or Bowel Disease

Neurological
- ☐ Concussions
- ☐ Convulsions/Seizures
- ☐ Migraines/Severe Headaches
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Stroke/TIA

Mental Health
- ☐ ADHD
- ☐ Alcohol Abuse
- ☐ Anorexia *(Eating Disorder)*
- ☐ Anxiety Disorder
- ☐ Bulimia *(Eating Disorder)*
- ☐ Depression
- ☐ Drug Dependency
- ☐ Other Mental Health Problems

Hematology/Oncology
- ☐ Anemia
- ☐ Bleeding Disorders
- ☐ Blood Clots/Clotting Disorders
- ☐ Cancer
- ☐ Radiation Therapy

Orthopedics
- ☐ Arthritis
- ☐ Fractures/Broken Bones

Infectious Diseases
- ☐ Chickenpox/Varicella
- ☐ Hepatitis Type: _____
- ☐ HIV Infection
- ☐ Infectious Mononucleosis
- ☐ Malaria
- ☐ Mumps
- ☐ Tuberculosis
- ☐ Typhoid Fever

Skin
- ☐ Eczema
- ☐ Psoriasis
- ☐ Hives

STDs
- ☐ Chlamydia
- ☐ Genital Herpes
- ☐ Genital Warts
- ☐ Gonorrhea
- ☐ HPV
- ☐ Other STD

Surgical History
- ☐ Appendectomy
- ☐ Adenoidectomy
- ☐ Ear Tubes
- ☐ Gallbladder Removal
- ☐ Knee ACL Repair
  L ___ R ___
- ☐ Knee Arthroscopy
  L ___ R ___
- ☐ Organ Transplant
- ☐ Ovarian Cyst Removal
- ☐ Splenectomy
- ☐ Tonsillectomy
- ☐ Weight Loss Surgery
- ☐ Other Prior Surgeries

_____

Social History
- ☐ Do you drink alcohol?
- ☐ Do you exercise regularly?
- ☐ Do you take recreational drugs?

OB/GYN History
- ☐ Endometriosis
- ☐ Pregnancies #: _____

Exercise History
- ☐ Lack of exercise
- ☐ Exercising regularly

Moderate Exercising
Walking briskly, water aerobics, etc.
- ☐ Less than 3 times per week
- ☐ 3 or more times per week

Strenuous Exercising
Running, swimming laps, etc.
- ☐ Less than 3 times per week
- ☐ 3 or more times per week

☐ **NO Significant Health Problems**

Be prepared to inform the nurse of current medications *(include birth control, acne, over the counter medications, vitamins, etc.)*

Allergies
Have you ever had an allergic reaction? ☐ **Yes** ☐ **No**

Medication Allergies: _____

Food Allergies: _____

Other Allergies (latex, beestings, etc.): _____

Other History
☐ Previous Hospitalizations _____

_____

☐ 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)				
Diabetes					
Drug Dependency					
Heart Disease					
High Blood Pressure					
High Cholesterol					
Mental Illness					
Stroke					
Sudden Cardiac Arrest (under age 50)					
Other (Please explain)					
Parent Deceased					