

| PLEASE PRINT   |                               |                                 | DRUG ALLERGIES OR REACTIONS |
|----------------|-------------------------------|---------------------------------|-----------------------------|
| NAME: Last     | First                         | MI                              | 1.                          |
| Date of Birth: | Age:                          |                                 | 2.                          |
| Studies Major: |                               |                                 | 3.                          |
| Student ID #   | <input type="checkbox"/> male | <input type="checkbox"/> female | 4.                          |

**MEDICAL HISTORY: Do you have a present or past history of: (check all that apply)**

**GENERAL**

- Fatigue
- Sleep Problems
- Weakness
- Weight Loss
- Other \_\_\_\_\_

**MENTAL**

- Abuse
- ADD/ADHD
- Alcoholism
- Anorexia
- Anxiety
- Bipolar Disorder
- Bulimia
- Depression
- Drug abuse or addiction
- Obsessive compulsive Disorder
- Panic Attacks
- Sexual Assault
- Other \_\_\_\_\_

**NEUROLOGICAL**

- Fainting
- Head Injury/concussion
- Migraine Headaches
- Multiple Sclerosis
- Recurrent Headaches
- Seizures
- Other \_\_\_\_\_

**EYES**

- Blindness
- Eye Trauma
- Other \_\_\_\_\_

**EARS, NOSE, THROAT**

- Hearing loss
- Recurrent nose bleeds
- Recurrent sinus infections
- Animal allergies
- Seasonal allergies
- TMJ problems
- Other \_\_\_\_\_

**LUNGS**

- Asthma
- Exercise induced Asthma
- Pneumonia
- Recurrent bronchitis
- Other \_\_\_\_\_

**CARDIOVASCULAR**

- Chest pain
- Congenital heart defect
- Heart Murmur
- High blood pressure
- High cholesterol
- Palpitations/Arrhythmia
- Valvular heart problems
- Other \_\_\_\_\_

**GENITOURINARY**

- Kidney Infection
- Kidney stones
- Recurrent bladder infections
- Other \_\_\_\_\_

**GYNECOLOGICAL (WOMEN)**

- Abnormal PAP test
- Abnormal vaginal bleeding
- Breast cancer
- Breast lump
- Cervical cancer
- Endometriosis
- Menstrual irregularities
- Ovarian cysts
- Pelvic infection (PID)
- Pregnancy or plans to get pregnant
- Vaginal infection
- Other \_\_\_\_\_

**MUSCULOSKELETAL**

- Arthritis
- Joint pain
- Fibromyalgia
- Herniated disc
- Recurrent back pain
- Scoliosis
- Other \_\_\_\_\_

**GASTROINTESTINAL**

- Celiac disease
- Constipation
- Crohn's disease
- Diarrhea
- Gall bladder disease
- Hemorrhoids
- Irritable bowel syndrome
- Recurrent heartburn/GERD
- Ulcer
- Ulcerative colitis
- Other \_\_\_\_\_

**ENDOCRINE**

- Diabetes type I
- Diabetes type II
- Hyperthyroid
- Hypothyroid
- Kidney or liver problems
- Polycystic Ovarian Disease
- Thyroid nodule
- Other \_\_\_\_\_

**BLOOD DISORDERS**

- Absence of spleen
- Anemia
- Blood transfusion
- Cancer
- Clotting disorder
- Immune system deficiency
- Leukemia
- Lymphoma
- Sickle cell disease
- Thalassemia
- Other \_\_\_\_\_

**DERMATOLOGY**

- Acne
- Eczema
- Psoriasis
- Rash
- Recurrent hives
- Skin cancer
- Other \_\_\_\_\_

**SOCIAL HISTORY**

In accordance with HIPPA regulations, all information reported here is confidential.

Do you now use any of the following?

- Tobacco
- Marijuana
- Other recreational drugs
- Stimulants (non-medical use)
- Other prescription drugs

How often do you consume alcohol?

- Never
- Monthly or less
- 2 to 4 times a month
- 2 to 3 times a week
- 4 or more times a week

When you drink, how much do you typically drink in one day?

- None
- 1-2 alcoholic beverages
- 3-4
- 5-6
- 7-8
- 10 or more

Do you have pets? If so which ones? \_\_\_\_\_

**FAMILY HISTORY**

Has any close relative (parents, siblings, grandparents, aunts, uncles) ever had any of the following?

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> I am adopted   | <input type="checkbox"/> Psychological disorder | <input type="checkbox"/> Melanoma              |
| <input type="checkbox"/> Alcoholism     | <input type="checkbox"/> Diabetes               | <input type="checkbox"/> Mental health problem |
| <input type="checkbox"/> Asthma         | <input type="checkbox"/> Drug addiction         | <input type="checkbox"/> Ovarian cancer        |
| <input type="checkbox"/> Anemia         | <input type="checkbox"/> Heart disease          | <input type="checkbox"/> Phlebitis             |
| <input type="checkbox"/> Blood clots    | <input type="checkbox"/> High blood pressure    | <input type="checkbox"/> Stroke                |
| <input type="checkbox"/> Breast cancer  | <input type="checkbox"/> Hereditary disease     | <input type="checkbox"/> Suicide               |
| <input type="checkbox"/> Cancer (other) | <input type="checkbox"/> High cholesterol       | <input type="checkbox"/> Thyroid disorder      |
| <input type="checkbox"/> Colon cancer   | <input type="checkbox"/> Kidney disease         | <input type="checkbox"/> Tuberculosis          |

**SURGICAL/HOSPITALIZATION HISTORY**

Please list your surgical history: (please enter none if you have never had any surgeries in the past)

Surgery (i.e.: appendectomy, pinning of fractures, etc.)

Date

| Surgery (i.e.: appendectomy, pinning of fractures, etc.) | Date |
|--|------|
|  |      |
|  |      |
|  |      |
|  |      |

Please list any hospitalizations not included in surgical history: (please enter none if you have never been hospitalized)

Hospitalization (i.e. emergency room, overnight stay, etc.)

Date

| Hospitalization (i.e. emergency room, overnight stay, etc.) | Date |
|---|------|
|   |      |
|   |      |
|   |      |
|   |      |

**CURRENT MEDICATIONS**

Please list all medications you currently take, including over the counter:

Medication and dose:

How often

| Medication and dose: | How often |
|----------------------|-----------|
|                      |           |
|                      |           |
|                      |           |
|                      |           |