CONFIDENTIAL Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MEDICAL HISTORY FORM

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you: Smoke?\_\_\_\_\_\_\_\_\_\_\_\_\_ Packs per day\_\_\_\_\_\_\_\_\_\_ # Years smoked\_\_\_\_\_\_\_\_\_\_\_\_\_

Drink Alcohol?\_\_\_\_\_\_\_\_ Drinks per day\_\_\_\_\_\_\_\_\_\_\_

Drink cola/coffee?\_\_\_\_\_ How much per day?\_\_\_\_\_\_\_

List the medications you are now taking:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any allergies you have to drugs, food or other items:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently under medical care for any reasons? If yes, please explain:

WOMEN ONLY:

Age when menstrual periods began \_\_\_\_\_\_\_\_\_\_\_\_

Are your periods regular? \_\_\_\_\_\_\_\_\_\_\_\_ How often?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many days do your periods last? \_\_\_\_\_\_\_\_\_\_\_\_

How many times have you been pregnant? \_\_\_\_\_\_\_\_\_\_\_\_

How many children born alive? \_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Physician: Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address and City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Past Psychiatric/Mental Health Care:

Provider’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ For How long?\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List All Operations:

Operation Performed Year Hospital Doctor

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List all times you have been admitted to a hospital for an emergency/observation (except for childbirth)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check if any relative (parents, siblings, grandparents, children) have had any of the conditions listed below:

High blood pressure: \_\_\_\_\_\_\_ Kidney Disease: \_\_\_\_\_\_ Asthma: \_\_\_\_\_\_

Stroke: \_\_\_\_\_\_\_ Bleeding Tendencies: \_\_\_\_\_\_ Tuberculosis: \_\_\_\_\_\_

Cancer: \_\_\_\_\_\_\_ Seizures: \_\_\_\_\_\_ Colitis: \_\_\_\_\_

Emphysema: \_\_\_\_\_\_\_ Heart Disease: \_\_\_\_\_\_ Anemia: \_\_\_\_\_\_

Ulcers: \_\_\_\_\_\_\_ Sugar Diabetes: \_\_\_\_\_\_ Gout: \_\_\_\_\_\_

Mental Illness: \_\_\_\_\_\_\_ Other Serious Illness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any of the following illnesses: (Please Circle)

Measles Diabetes Typhoid

Rubella (German Measles) Goiter, Thyroid Disease Malaria

Chickenpox Hives Other Tropical Diseases

Mumps Allergies Hepatitis

Whooping Cough Eczema Venereal Disease

Scarlet Fever Mono Seizures

Tonsillitis Rheumatic Fever Meningitis

Diphtheria Poliomyelitis Ear Infections

Asthma Pleurisy Heart Murmur

Glaucoma Bronchitis High Blood Pressure

Cancer Influenza Low Blood Pressure

Angina Pectoris Tuberculosis Heart Attack

Ulcer Phlebitis Kidney Stones

Bladder or Kidney Infection

Other serious illnesses: (Please Explain):

Please list the date and results (if known) of your last:

X-ray\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EKG:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Blood Count:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last examination by a doctor:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

It should be noted that medications may have unwanted side effects. You are strongly urged to bring to our attention any problem that you may be having with your medications.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student Signature Date

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