Student Health Center
Medical History Form

Appendix 22

Date: _____
Name: _____
Date of Birth: _____
Jag #: _____

PERSONAL: (Circle those that apply)

Diabetes	Hypertension	Heart Attack	Peripheral Vascular Disease	Sleep Apnea	Arrhythmia
Heart Failure	Asthma	Tuberculosis	Emphysema/COPD	Crohn's Disease	Barrett's Esoph
Acid Reflux	Peptic Ulcer	Hemorrhoids	Ulcerative Colitis	Ulcerative Colitis	Anxiety
Kidney Stones	Renal Failure	Thyroid Disease	Stroke	Systemic Lupus	Bipolar
Bleeding Problems	Seizure Disease	Rheumatoid	Depression	ADHD	

Cancer: _____
Injuries: _____
Surgeries:
_____
Hospitalizations:
_____
Other:
_____
Current Medications including over the counter pills/herbal medicines:
_____
Known allergies: _____
Are you up to date with vaccinations? (If not sure, please provide the records) YES NO Last tetanus shot: _____

FAMIY HISTORY: (Please circle if father, mother, sister, brother or your child has been diagnosed with any below)
Diabetes Asthma Heart Problems High Blood Pressure High Cholesterol Thyroid Disease
Thyroid Disease Cancer _____ Sudden unexplained death of a family member

DO YOU HAVE ANY OF THE FOLLOWING: (Please circle)

Fever	Chills	Night Sweats	Loss of Appetite	Involuntary Weight Loss	Fatigue
Nose Congestion	Sore Throat	Earache	Problems Swallowing	Toothache/ Chest Pains	Skipped/ Irregular Heart beat
Fainting/near fainting episodes	Shortness of Breath	Cough	Wheezing	Stomach Pain	Nausea
Vomiting	Constipation or Diarrhea	Blood in Stool	Burning of urination	Frequent Urination	Incontinence
Problems with Joints	History of Bone Fractures	Back Pain	Skin Lesions or Rashes	Changes in Color of Mole	Bleeding or easily bruising
Enlarged/ Swollen Glands	Headache	Dizziness	Numbness	Sensation of pins or needs in a part of your body	Weakness in one of your limbs

ADDITIONAL QUESTIONS:
Are you having any problems with vision or hearing? YES NO
Have you felt depressed, feeling down and hopeless during the past month? YES NO
During the past month, have you often been bothered by little interest or pleasure in doing things? YES NO
Do you use recreational (e.g., marijuana, cocaine, speed, etc) drugs? YES NO
Do you exercise? YES NO Do you consider your diet healthy? YES NO
Do you always wear seatbelts?? YES NO Do you smoke? YES NO
Do you drink? YES NO IF yes, how much? _____

MALES ONLY: Do you perform monthly self-testicular exams? YES NO

WOMEN ONLY:
When was your last Pap smear? _____ When was your last menstrual period? _____ Age of first menstrual period? _____
Have you had any abnormal Pap smears in the past? YES NO
Are your periods regular? YES NO Are your periods heavy? YES NO
Are you pregnant now? YES NO Are you planning a pregnancy YES NO
Do you have any vaginal bleeding between periods ? YES NO
Do you have any vaginal discharge? YES NO
Do you have any pelvic pain or discomfort? YES NO
Any breast lumps? YES NO Pain in breast? YES NO Nipple Discharge? YES NO
Number of times pregnant? _____ Number of completed pregnancies: _____
What method of birth control do you use? _____

I certify that the information given on this form is true and correct and I have no abnormality, limitation or restriction not mentioned on this document. I understand that any false information, willful or negligent, misrepresentation or failure to disclose any requested information could be sufficient grounds for dismissal from USA. I acknowledge by my signature that I have read and understand these statements. I hereby authorize the medical professionals of the USA Student Health Center to treat my medical conditions which appear indicated to them.

_____ _____
Signature Date