Medical History

CONFIDENTIAL

To be completed by the student.

Name: ____ Male ☐ Female ☐

Last *First* *Middle*

FAMILY HISTORY (Has a blood related parent, grandparent or sibling ever had any of the following? If Yes, indicate relationship)

Condition	Yes	No	Relationship	Condition	Yes	No	Relationship
Alcohol/Drug addiction				Headaches			
Anemia				Heart disease			
Arthritis				High blood pressure			
Asthma				Kidney disease			
Cancer				Mental illness			
Deceased (Age)				Stroke			
Diabetes				Tuberculosis			
Epilepsy							

Please list number of brothers, sisters and their ages ______________________________

Are you adopted? Yes ☐ No ☐ If your parents are divorced, how old were you at the time of divorce?_______________

With whom do you live? Parents ☐ Mother ☐ Father ☐ Spouse ☐ Self ☐ Other ☐ ______________________

PERSONAL HEALTH HISTORY (If Yes, use the comments section to provide additional details such as dates)

Do you now or have you ever had:	Yes	No	Do you now or have you ever had:	Yes	No
Alcohol/Drug addiction			Persistent cough		
An abusive/controlling relationship			Persistent dental problems		
Anaphylactic shock (Explain)			Seasonal allergies		
Anemia, other blood disorder			Seizures		
Anxiety or depression			Serious disease of eyes or ears		
Asthma			Severe head injury, concussion		
Bad reaction to drugs, insect bites or food			Sickle Cell		
Cancer, other tumors			Skin disorder		
Chickenpox (If Yes, date____________)			Sleep difficulties		
Chronic fatigue syndrome			Smoke (tobacco/other substances)		
Diabetes			STD (Sexually transmitted disease)		
Disorder of muscle, bone or joint (List)			Suicide attempts		
Eating disorders			Thyroid, other endocrine disorder		
High blood pressure			Tuberculosis		
High cholesterol			Vision or hearing impairment		
Hospitalization (List)			**MEN ONLY**		
Intestinal bleeding/chronic abdominal pain			An undescended testicle, testicular mass, lump		
Jaundice, hepatitis			**WOMEN ONLY**		
Kidney disease or bladder problems			Gyn. Exam (If Yes, date _______________)		
Learning disability			Problems with menstrual periods		
Lyme disease			Abnormal pap		
Malaria, other tropical disease (List)			Abortion, miscarriage, pregnancy (List)		
Migraine headache			**SPORTS HISTORY**		
Mononucleosis			Participated in sports in the past two years?		
Obsessive compulsive disorder			Plan to participate in sports while at FDU?		
Operations or serious injuries (List)			Ever been disqualified from a sport due to illness or injury?		

Are there other aspects of your health that might cause problems for you or require special arrangements?	Yes	No

COMMENTS (For additional comments use back of form)

SOCIAL HISTORY

Life Habits

Have you in the past, or do you currently use:	**Y**	**N**	**Do you:**	**Y**	**N**
Cigarettes?			Feel out of control when you are stressed?		
If yes, at what age did you start?			Wear a seat belt 90% of the time?		
If yes, how many cigarettes a day?			Wear a bicycle/motorcycle helmet?		
Recreational drugs (ecstasy, cocaine, heroine, etc.)?			Understand and regularly perform a self breast or self testicular exam?		
Chewing tobacco, or marijuana?			Practice safer sex?		
Alcohol? (If yes, fill out survey below)			Have a history of any sexually transmitted disease?		
Steroids?			Have a history of more than two sexual partners in the last 6 months?		
Vitamins or Supplements?			Have a history of depression or feel depressed?		

Nutritional Concerns

What is your present weight?			Have you ever gained/lost 10 lbs or more in a year?		
Are you happy with your present weight?			Do you ever feel out of control of your eating patterns?		
If No, what is your desired weight?			Have you ever had an eating disorder?		
How many meals do you eat each day?			Do you avoid certain food groups (carbohydrates, protein, meat, fats, salt, other)?		
Do you diet regularly?					
Have you tried to control your weight by: (check appropriate) Excessive exercise☐ Dieting/Fasting☐ Vomiting ☐ Diet pills☐ Laxatives ☐ Diuretics☐			Why? Have any additional concerns?		

Alcohol Survey

If you drink alcohol, answer the following questions by selecting an option that comes closest to your answer:	**Never**	**Yearly**	**Monthly**	**Weekly**	**Daily**
How often do you have an alcoholic drink?					
How often do you have 4 or more drinks on occasion					
How often in the last year have you found you were unable to stop drinking once you've started?					
How often in the last year have you failed to do what was normally expected of you because of drinking?					
How often in the last year have you needed a drink in the morning to get yourself going after a heavy night of drinking?					
How often during the last year have you been unable to remember what happened the night before because of your drinking?					
Please circle the closest answer:					
How many alcoholic drinks do you have on a typical day?	0 to 2	3 to 5	6 to 8	9 to 10	10 or more
Have you or someone else been injured as a result of your drinking?	No	Yes, but not in the last year		Yes, in the last year	
Has a relative, friend, doctor or other health worker been concerned about your drinking or suggested you cut down?	No	Yes, but not in the last year		Yes, in the last year	

I ________________________________ declare that all of the above information is true to the best of my knowledge.

Student Signature: ____ Date: ________________

This information will be used only as a background for providing health care