

**HEALTH CENTER at AURARIA
MEDICAL HISTORY**

(PLEASE PRINT)

(THIS INFORMATION IS FOR CONFIDENTIAL USE ONLY AND WILL NOT BE RELEASE UNAUTHORIZED)

LAST NAME –FIRST NAME-MIDDLE NAME OR INITIAL	TODAY'S DATE	BIRTH DATE	STUDENT/STAFF ID #
NICKNAME:			

MARRIED **SINGLE** **Number of Pregnancies** _____ **Live Births** _____ **Last PAP** _____ **Normal?** _____
(date)

HAVE YOU EVER HAD?

Please check yes or no

FAMILY HISTORY

Have any of your **immediate family members** had or have
(M=Mother F=Father S=Sister B=Brother)

Y E S	N O	DATE OF ONSET (if yes)		RELATIONSHIP AND AGE OF ONSET		<input type="checkbox"/> Adopted – No Family History Available
				Y E S	N O	
			HEART <input type="checkbox"/> HIGH BLOOD PRESSURE <input type="checkbox"/> HIGH CHOLESTEROL <input type="checkbox"/> HEART ATTACK			BREAST CANCER
			STROKE, BLOOD CLOTS, SEIZURES			OVARIAN CANCER
			LIVER DISEASE			UTERINE CANCER
			MIGRAINES			COLON CANCER
			THYROID			HEART ATTACK BEFORE AGE 50
			DEPRESSION/ANXIETY			STROKE
			DRUG OR ALCOHOL PROBLEM			BLOOD CLOTS
			ASTHMA			HIGH BLOOD PRESSURE
			ALLERGIES			DIABETES

Other Illnesses or Conditions not Listed Above

If none check here

Adverse Reaction to Medication, Insect Bites, Chemicals, etc.

No Known Drug Allergies Latex Allergy

HOSPITALIZATIONS, INJURIES, SURGERY (please include month and year)

If none check here

ROUTINELY USED MEDICATION (please include birth control, inhalers, multivitamins, herbal supplements)

If none check here

LIFESTYLE QUESTIONS

DO YOU USE:

Alcohol ___yes___ ___no___ How much? ___ ___ How often? ___ ___
Drugs ___yes___ ___no___ Which ones? ___ ___ How often? ___ ___
Tobacco ___yes___ ___no___ How much? ___ ___ Do you wish to quit? ___yes___ ___no___

School _____ Major _____

Expected graduation _____

To the best of my knowledge, the information on this health form is correct as of this date.

Patient Signature

Date