

Student Health Center

Date _____
Name _____
Date of Birth _____
JAG# _____

PERSONAL

- | | | | | | |
|--|--|--|--|---|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Peripheral Vascular Disease | <input type="checkbox"/> Arrhythmia | |
| <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Asthma | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Emphysema/ COPD | <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Barrett's Esoph. |
| <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Peptic Ulcers | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Ulcerative Colitis | <input type="checkbox"/> Crohn's Disease/Ulcerative Colitis | |
| <input type="checkbox"/> Renal Stones | <input type="checkbox"/> Renal Failure | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> Systemic Lupus | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Seizure disease | <input type="checkbox"/> Rheumatoid | <input type="checkbox"/> Depression | <input type="checkbox"/> ADHD | <input type="checkbox"/> Bipolar |
- Cancer (s) _____
 Injuries _____
 Surgeries _____
 Hospitalization _____
 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? _____

FAMILY HISTORY: Please circle who has it: father / mother / sister / brother / children

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Cancer | _____ |
- Sudden/ unexplained death of a family member

DO YOU HAVE ANY OF THE FOLLOWING?

- | | | | | | |
|---|---|---|--|--|-----------------------------------|
| <input type="checkbox"/> Fever | <input type="checkbox"/> chills | <input type="checkbox"/> night sweats | <input type="checkbox"/> loss of appetite | <input type="checkbox"/> involuntary weight loss | <input type="checkbox"/> fatigue |
| <input type="checkbox"/> Nose congestion | <input type="checkbox"/> sore throat | <input type="checkbox"/> earache | <input type="checkbox"/> problems with swallowing | <input type="checkbox"/> toothache | |
| <input type="checkbox"/> Chest pains | <input type="checkbox"/> skipped heart beats or irregular heart beats | <input type="checkbox"/> fainting or near fainting episodes | | | |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> cough | <input type="checkbox"/> wheezing | <input type="checkbox"/> Stomach pain | <input type="checkbox"/> nausea | <input type="checkbox"/> vomiting |
| <input type="checkbox"/> constipation or diarrhea | <input type="checkbox"/> blood in stool | | | | |
| <input type="checkbox"/> Problems with urination | <input type="checkbox"/> burning on urination | <input type="checkbox"/> frequent urination | <input type="checkbox"/> incontinence | | |
| <input type="checkbox"/> Problems with your joints | <input type="checkbox"/> history of bone fractures | <input type="checkbox"/> Back pain | <input type="checkbox"/> skin lesions or rashes | | |
| <input type="checkbox"/> change in size or color of a mole? | <input type="checkbox"/> Bleeding or easy bruising | <input type="checkbox"/> Enlarged/Swollen glands | | | |
| <input type="checkbox"/> headaches | <input type="checkbox"/> dizziness | <input type="checkbox"/> numbness | <input type="checkbox"/> sensation of pins or needles in a part of your body | <input type="checkbox"/> weakness in one of your limbs | |

Having any problems with vision or hearing? Yes No
Have you felt depressed, feeling down and hopeless during the past month? Yes No
Do you use any 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 seat belts? Yes No Do you smoke? Yes No
Do you drink? Yes No If yes, how much? _____
How many sexual partners have you had in the last 12 months? _____

MALES ONLY: Do you perform monthly self-testicular exams? Yes No

FOR 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 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 Signed _____