**Student Name** _____ **Date of Birth** _____

# Personal Health History p.1

**CONFIDENTIAL MEDICAL HISTORY:** On the following pages, if you need to list additional items or explanations, utilize any extra space within the section or continue on the back side of the appropriate page (making note of this within that section).

* The information you provide here will be kept within the SHAC office. If you would like to request academic accommodations for any health condition disclosed here, please contact Disability Resource Center at drc@samuelmerritt.edu

Check all that apply, if you have or have had any of the following.

- ☐ Allergies
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Auto-immune disease
- ☐ Back injury or surgery
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Drug/alcohol abuse
- ☐ Eating disorder
- ☐ Emotional abuse
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Frequent urine infection
- ☐ Hearing problems
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ High blood pressure
- ☐ Kidney disease
- ☐ Learning disability
- ☐ Lupus erythematosis
- ☐ Migraine headache
- ☐ Neurological disorders
- ☐ Physical abuse
- ☐ Sexual relations against your will
- ☐ Sickle cell disease
- ☐ Skin problems
- ☐ Stomach or bowel ulcers
- ☐ Tuberculosis
- ☐ Vision problems
- ☐ Weight loss or gain

☐ **NONE of the above**

# Surgeries and Hospitalizations

List dates, types of surgery (if applicable), and reasons for hospitalization.

| Date | Surgery or Hospitalization |
|---|---|
| | |
| | |
| | |

Describe any other significant health conditions you may have, including physical limitations: _____

Provide details of any conditions that you have indicated above.

| Condition & Current Status | How Controlled | Dates of Onset & When Resolved |
|---|---|---|
| | | |
| | | |
| | | |

☐ **No Surgery or Hospitalization**

**Student Name** _____ **Date of Birth** _____

## Personal Health History: Allergies p.2

List allergies to any medications and other substances, and describe the type of reaction to each.

| Allergy | Reaction |
|---|---|
| | |
| | |
| | |
| | |

☐ **NO Known Drug/Allergies**

## Medications

List all medications you are currently taking. Include birth control pills, vitamins, medicinal herbs, and non-prescription medications.

| Medication | Dose & Frequency | Reason for taking this medicine |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

☐ **NONE**

## Personal Habits

Briefly describe your current dietary and exercise habits.

Check all that apply:

| | How much? | | How much? |
|---|---|---|---|
| ☐ Smoke Cigarettes | | ☐ Recreational Drugs | |
| ☐ Smoke cigars | | ☐ Drink coffee | |
| ☐ Chew tobacco | | ☐ Drink tea | |
| | | ☐ Drink alcohol | |

Diet: _____

Exercise: _____

**Student Name** _____ **Date of Birth** _____

# Personal Health History: Family p.3

**Family Health History: Please check all that apply**

| Illness | Mother | Father | MGM* | MGF* | PGM* | PGF* | Siblings | Children |
|---|---|---|---|---|---|---|---|---|
| Alcoholism | | | | | | | | |
| Allergies | | | | | | | | |
| Asthma | | | | | | | | |
| Cancer, breast | | | | | | | | |
| Cancer, other ** | | | | | | | | |
| Chronic lung disease | | | | | | | | |
| Diabetes | | | | | | | | |
| Heart disease | | | | | | | | |
| High blood pressure | | | | | | | | |
| Osteoporosis | | | | | | | | |
| Stroke | | | | | | | | |
| Thyroid disease | | | | | | | | |

* *MGM (maternal grandmother), MGF (maternal grandfather), PGM (paternal grandmother), PGF (paternal grandfather)*

** For other cancer, please listtype: _____

☐ **NONE of the above**

# Social History

List all current members of your household. Include spouse or significant other, children, other family members, and any other people who live with you.

| Name | Relationship | Age | Current Health Status |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## Sexual History (Optional)

Date of last Pap smear:_____

Do you think you could be pregnant now?__Yes __No

Any pregnancies?___Yes___No How many?_____

Have you ever had sexual contact? ___ Yes ___ No

If yes, with: ____ Penis ____Vulva ____ Both

Number of lifetime partners: _____

Protection use: ___ Always ___ Sometimes ___ Never