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
- ☐ Non-consensual sexual contact
- ☐ 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								
Depression								
Anxiety								
Asthma								
Cancer**								
Chronic lung disease								
Diabetes								
Heart disease								
High blood pressure								
Osteoporosis								
Allergies								
Thyroid disease								

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

Have you ever had sexual contact? Y/N

If yes, with: Penis/Vulva/Both

Protection use: Always/Sometimes/Never

Would you like to discuss about STI screening? Y/N

Date of Last Pap Smear: _____

Any pregnancies? Y/N
If Yes, how many? _____

Do you think you could be pregnant now? Y/N

Would you like a pregnancy test today? Y/N