UAH Health Services

Medical History

Private and Confidential

Date _____/_____/_____

Name _____ Age _____ Birthdate_____/_____/_____

Preferred Pronoun(s)_____

What is your gender identity now?
- ○ Male
- ○ Female
- ○ Non-binary
- ○ Prefer not to say
- ○ Other _____

What sex were you assigned at birth?
- ○ Male
- ○ Female
- ○ Other _____

Allergies to Medications, X-Ray Dyes, or Other Substances ☐ No ☐ Yes

_____ _____ _____ _____

_____ _____ _____ _____

Personal Past Medical History and Review of Systems

Please circle if <u>you</u> have had problems with or are presently experiencing any of the following:

1. High blood pressure
2. Diabetes
3. Cancer
4. Heart disease
5. Chest pain/chest tightness
6. Shortness of breath
7. Swollen ankles
8. Palpitations
9. Lightheadedness
10. Frequent urination
11. Rheumatic fever
12. Asthma
13. Bronchitis
14. Pneumonia
15. Persistent cough
16. T.B.
17. Hay fever
18. Abdominal discomfort
19. Indigestion
20. Nausea
21. Vomiting
22. Constipation
23. Diarrhea
24. Blood in stool
25. Ulcers
26. Change in bowel habits
27. Unexplained weight gain/loss
28. Hemorrhoids
29. Gall bladder disease
30. Colitis
31. hepatitis or jaundice
32. Thyroid disease
33. Head or neck radiation
34. Headache
35. Kidney disease
36. Kidney stones
37. Difficulty urinating
38. Arthritis
39. Low back problems
40. Skin diseases
41. Blood disorders
42. Venereal diseases
43. Anxiety
44. Depression
45. Anemia
46. Alcohol abuse
47. Drug abuse
48. Gout
49. _____
50. _____
51. _____
52. _____

_____

_____

Gynecologic and Obstetric History

Age at onset of periods: _____ Frequency: _____ Length of period: _____

Pregnancies: _____ Live Births: _____

Please List and Supply the Date of:

Surgeries: _____ _____ _____

_____ _____ _____

Hospitalizations other than for surgery: _____ _____

_____ _____ _____

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Immunization history – have you had:

Tetanus Immunization?	☐No	☐Yes	When? _____
Hepatitis B?	☐No	☐Yes	When? _____
Flu immunization?	☐No	☐Yes	When? _____
Pneumovax Immunization?	☐No	☐Yes	When? _____
COVID-19?	☐No	☐Yes	When? _____
Other _____	☐No	☐Yes	When? _____

Screening Tests - ***When was your last:***

Pap smear: _____ Breast exam: _____ Colonoscopy/Stool check for blood: _____

Mammogram: _____ Cholesterol check: _____ Prostate exam: _____

Family History

Has any member of your family (including parents, grandparents, and siblings) ever had the following?

Illness	**Which family members?**	**Approx. age when diagnosed**
Thyroid Disease (describe)	_____	_____
Cancer (describe type)	_____	_____
Hypertension (high blood pressure)	_____	_____
Heart disease/heart attack	_____	_____
Diabetes	_____	_____
Strokes	_____	_____
Mental disease (anxiety, depression, etc.)	_____	_____
Drug or alcohol addiction	_____	_____
Glaucoma	_____	_____
Bleeding diseases	_____	_____
Other	_____	_____

Medications (Prescription, Over-the-Counter, Vitamins, Herbs, etc.)

Drug Name	Dose	Drug Name	Dose
_____		_____	
_____		_____	
_____		_____	

Prevention

Do you wear seat belt?	☐ Yes	☐ No	If no, why not? _____
Do you wear a bike helmet?	☐ Yes	☐ No	☐ N/A
Do you exercise regularly?	☐ Yes	☐No	If yes, type, duration and # of times per week? _____
Do you smoke/vape/chew or dip tobacco?	☐ No	☐ Yes	If yes, how much and how often per day? _____
Do you drink alcoholic beverages?	☐ No	☐ Yes	If yes, how much per week? _____
Do you drink caffeine? (Coffee, tea, energy drinks)	☐ No	☐ Yes	If yes, how many per day? _____
If there is a gun in your home, do you keep it unloaded and out of children's reach?	☐ Yes	☐ No	☐ N/A
Do you use drugs? (marijuana, cocaine, crack, etc.)	☐ No	☐ Yes	If yes, explain: _____
Have you ever engaged in any activity which has put you at risk of getting HIV?	☐ No	☐ Yes	If yes, explain: _____
Do you wish to be tested for HIV?	☐ No	☐ Yes	
Have you ever worked with chemicals, asbestos, or other hazardous materials?	☐ No	☐ Yes	If yes, explain: _____