

In order to provide you with more effective medical care, basic information is needed about your medical history. The time you spend completing this will be an important contribution to your overall health care.

Take whatever time you need and don't worry if you can't remember or aren't sure of the answer or any part of the question. Your health care provider will go over the form with you.

THIS FORM IS CONFIDENTIAL AND IS NOT AVAILABLE TO ANYONE OUTSIDE OF THE RUTGERS UNIVERSITY HEALTH SERVICES WITHOUT YOUR WRITTEN PERMISSION

NAME _____

Social Security # _____

FAMILY HISTORY: For each member of your family check boxes for:

1. Their present state of health
2. Any illness they have had

Good Health
Poor Health
Deceased

If deceased, write in age and cause of death. Include fatal accidents and suicides.

Family Member	Good Health	Poor Health	Deceased	Allergies	Anemia	Asthma	Diabetes	Cancer or Tumor	Epilepsy	Headaches	Sickle Cell Disease	Alcoholism	Problems with Drugs	Tuberculosis	Mental Health Problems	Sudden Death Before 50	High Blood Pressure	Heart Trouble	Stroke	Thyroid Problems	Cholesterol	
Mother																						
Father																						

Allergy

Any significant allergy to food, medications, latex, insects, pollen, or other allergens? Yes No
 Do you require adrenaline for insect stings? Yes No

Medications

Do you take any medications regularly, including herbals, supplements and over-the-counter drugs? Yes No
 If yes, please list specific medications: _____

Hospitalization

Have you ever been admitted to a hospital? Yes No
 Have you ever had surgery? Yes No

Past Illnesses

Please list significant past illnesses, such as Hepatitis and Mononucleosis, including childhood diseases: _____

Drug and Alcohol Usage

Have you ever felt you should cut down on your drinking? Yes No
 Have people annoyed you by criticizing your drinking? Yes No
 Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? Yes No
 Please give specific information about drug usage including ecstasy, GHB, marijuana, etc. : _____

Accident Prevention

Do you usually wear a seat belt when you ride in a car? Yes No
 Do you wear protective equipment when participating in a sports act? Yes No

Mental Health

Any problems with your emotional health, requiring any form of therapy, including medication? Yes No
 Do you feel you are having trouble managing your stress? Yes No

Miscellaneous

Did you ever lie to anyone about your gambling? Yes No
 Does anyone presently in your life hurt you or make you feel afraid? Yes No

Eye, Ear, Nose and Throat

Any problems with your eyes, ears, nose or throat? Yes No

Cardiovascular

Heart Murmur? Yes No
 Chest Pain? Yes No
 Rheumatic Fever? Yes No
 High Blood Pressure? Yes No
 Irregular Heartbeat? Yes No
 Phlebitis or Blood Clots (except menstrual clots)? Yes No

(OVER)

Respiration Yes No

Asthma?

Chest Infections?

Do you smoke cigarettes?

How many _____ day for _____ years

If yes, do you want to quit?

Do you chew tobacco?

Skin

Any problems with your skin?

Health and Nutrition

Are you following a special diet?

If yes, which diet and why?

Does concern about your weight affect your behavior or mood?

Have you gained/lost 10 lbs in the past year?

Do you exercise regularly?

Digestive

Any problems with any part of your intestinal tract or stomach?

Urinary

Problems with any part of your urinary tract or kidney?

Any recurrent urinary tract infections?

Blood

Any blood abnormality (such as anemia)?

Bone and Joint

Any serious disability, deformity, injury, or disease of bone, joint, or muscle?

Neurology

Have you had seizures or convulsive disorder, blackouts, fainting spells, or recurrent headaches?

Endocrine

Thyroid Disease?

Diabetes?

YOUR SEXUAL HISTORY

Have you ever been sexually involved with another person?
Yes No

If yes, age at first encounter: _____

If yes, your partners are or have been:
Female Male Both

Number of lifetime sexual partners: _____

Do you have questions, or wish to discuss sexual orientation, sexual expression, masturbation, or any issues of sexuality?
Yes No

Do you use condoms?
Always Sometimes Never N/A

Other contraception?
Always Sometimes Never N/A

Which other contraception? _____

Have you ever had a sexually transmitted disease: (e.g. Herpes, Warts, Chlamydia, Gonorrhea, HIV (AIDS Virus), Syphilis)? Please circle the ones you have had.
Yes No

Men Only:

Have you ever had: Yes No

Abnormal penile discharge?

Blood in urine or semen?

Pain or burning on urination?

Frequency of urination?

Have you ever had a problem requiring a visit to a urologist?

Do you know about Self Testicular Exam?

Do you do it?

Women Only:

GYNECOLOGICAL HISTORY

_____ date of last GYN Exam

_____ age at onset of first period

_____ first day of last normal period

_____ avg. # days of menstrual flow

_____ avg. # tampons/pads used daily

_____ avg. # days between onset of each period

_____ any bleeding between periods?

_____ any skipped or missed periods?

_____ Do you get cramps?

_____ If yes, how do you treat them?

_____ Have your periods changed in the last year?

_____ If yes, in what way?

Any abnormal pap smears? Yes No

Any problems requiring a visit to a gynecologist? Specify:

Do you do a self breast exam?

Rutgers University Health Services supports patient's right to access medical records and ensures patient confidentiality and privacy

For Staff Use Only			
Initials	Date	Initials	Date
_____	_____	_____	_____
_____	_____	_____	_____