UNG UNIVERSITY of NORTH GEORGIA™

STUDENT HEALTH SERVICES MEDICAL HISTORY

NAME:____________________________________ ID:______________ DOB:______________DATE:______________

ADDRESS:____UNG BOX #____________

CITY, STATE, ZIP ____

How would you like to be contacted for results of tests sent out to the reference lab? (please circle)

Home address or Box number or Phone number--if phone number, please provide number:________________________

In case of emergency contact:

NAME:__________________________________ PHONE:___________________ RELATIONSHIP:__________________

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When was your last menstrual cycle? _____________________________ Was it normal?______________________
When was you last pap smear?____________________________________ Was it normal?______________________

Please check if you have ever had:

1) ___ High blood pressure
2) ___ Blood clots or stroke/When?_______
3) ___ Headaches/How often? ________
4) ___ Migraines/Diagnosed when?_______
5) ___ Numbness in arms or legs
6) ___ High cholesterol
7) ___ Anemia
8) ___ Eye problems (not related to glasses)
9) ___ Stomach or intestinal problems
10) ___ Liver or gallbladder problems
11) ___ Kidney or bladder problems
12) ___ Varicose veins
13) ___ Heart problems or murmur
14) ___ Cancer
15) ___ Depression
16) ___ Diabetes/Age?______
17) ___ Gynecological problems/surgery
18) ___ Breast disease/surgery
19) ___ Any surgeries not listed above
Procedure_____________________
20) ___ Any serious illness not listed above
Illness ________________________

Please check if :

21) ___ You are a smoker/Cigarettes per day ____
22) ___ You use alcohol/How much/day? _____________
23) ___ You feel alcohol/drugs are creating difficulties in your life.
24) ___ You have concerns about sexuality or sexual intercourse
25) ___ You do not feel safe in your current relationship
26) ___ You have experienced sexual assault/abuse
27) ___ You have experienced domestic violence

Family History:

Please make a check if your mother, father, sister or brother has had:

28) ___ Diabetes
29) ___ High cholesterol
30) ___ Heart attack/Age_____
31) ___ High blood pressure

Please make a check if your mother or sister has had:

32)___ Breast or ovarian cancer
33)___ Osteoporosis
34) ___Your mother took DES (a hormone given to prevent miscarriages) during her pregnancy with you
35)___You don't know your family history

Please check if you are currently having:

36) ___ Bleeding after intercourse
37) ___ Unusual vaginal bleeding
38) ___Vaginal itching
39) ___ Unusual vaginal discharge
40) ___ Bumps in genital area
41) ___ Pain/problem with urination
42) ___ Dizziness
43) ___ Blurred/double vision
44) ___Chest pain/shortness of breath
45) ___ Stomach/abdominal pain
46) ___ Pain/swelling in legs
47) ___ Numbness/tingling in extremities
48) ___ Breast lump/discharge from nipples
49) ___ Fever/chills
50) ___ Jaundice (yellowing of eyes/skin)
51) ___ Shoulder pain

Please answer the following questions regarding your periods:

52) How many days do your periods last? __________
53) Do you have periods every 24-35 days? __________
54) Do you have bleeding between periods? __________
55) How old were you when your periods began? __________
56) Do you have cramps requiring medication? __________
57) How many tampons/pads do you use on your heaviest days? __________

Please answer the following questions. They will help us determine your risk of having a sexually transmitted infection.

58) At what age did you first have sexual intercourse? ______
59) Are you currently having sexual intercourse? _____
60) Does your current partner have other partners? _____
61) How many partners have you had sexual intercourse with in the past year? _____
62) Are your sexual partners _____ men _____women _____ both
63) Do you use condoms? _____ always _____ occasionally _____never
64) Have you ever had _____ Chlamydia _____Gonorrhea _____ Trichomonas _____ Syphilis _____ Genital Herpes _____ Genital warts _____Pelvic Inflammatory Disease (PID) _____ Other sexually transmitted infections

65) **Gonorrhea and Chlamydia testing are available for a small additional cost. Do you desire this testing? _____ Yes _____ No Client Signature:___________________________________**

Birth Control History:
66) Check if you have ever used: ___Condoms ___Pills ___Spermicides ___Sponges ___Rhythm ___ Diaphragm ___ Cap ___ IUD ___ Norplant ___ Depo injections ___ Other ______________________________________
67) Describe any problems with past methods ____
68) What method(s) are you currently using? ______________________ How long _______ Problem? Yes No
69) What method(s) would you like today? ____

Pregnancy History:
70) Have you ever been pregnant? _____ *If no. sign and date form below.*
71) Have you ever had an infection after the birth of a child, abortion or miscarriage? ________________________
72) Number of living children ______

List your pregnancies in order below:
Number of weeks pregnant _______
Date pregnancy ended_________
How pregnancy ended ____abortion ____ miscarriage ____ live birth ____tubal pregnancy ____ fetal death/still born
What type of delivery _____ vaginal _____ c-section
Pregnancy complications ____ toxemia ____ genetic abnormality ____ gestational diabetes

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Client Signature ____________________________Staff Signature ________________________ Date _____________