

GEORGETOWN UNIVERSITY  
STUDENT HEALTH CENTER  
**MEDICAL HISTORY**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Student ID \_\_\_\_\_ Date \_\_\_\_\_

**Medical History:** To be filled out by the student and reviewed by your health care provider. Information on the medical history and physical examination is confidential and released only to persons you authorize in writing.

**Past Medical History** Major illness (list, date) \_\_\_\_\_  
 Surgeries (list, date) \_\_\_\_\_  
 Hospitalizations (list, date) \_\_\_\_\_  
 Accidents/injuries (list, date) \_\_\_\_\_  
 Allergies to medication \_\_\_\_\_  
 Current medications and dosage \_\_\_\_\_  
 \_\_\_\_\_  
 Over the counter & herbal medicines \_\_\_\_\_

**Habits** Smoking \_\_\_\_\_ packs per day Use of chewing tobacco \_\_\_\_\_  
 Alcohol \_\_\_\_\_ drinks per week  
 Drugs \_\_\_\_\_ type \_\_\_\_\_ frequency of use  
 Diet \_\_\_\_\_ number of meals/day  
 Exercise \_\_\_\_\_ hours/weeks \_\_\_\_\_ type of exercise  
 Do you use seat belts? \_\_\_\_\_ Do you use a bicycle helmet? \_\_\_\_\_  
 Do you use sunscreen? \_\_\_\_\_  
 Have you ever had intercourse? \_\_\_\_\_ Do you use condoms? \_\_\_\_\_  
 Any special dietary restrictions? \_\_\_\_\_  
 Social history: School \_\_\_\_\_ Job \_\_\_\_\_  
 Outside Activities \_\_\_\_\_

**Travel** Have you been outside the U.S.? \_\_\_\_\_  
 If so, where & when? \_\_\_\_\_  
 \_\_\_\_\_

**Family History**

	√ Living	√ Dead	Medical Problems of this Relative
Father			
Mother			
Sibling			
Sibling			

Who in your family (including you) has had:

- |                     |              |                          |
|---------------------|--------------|--------------------------|
| Diabetes            | Seizures     | Migraine                 |
| Kidney disease      | Tuberculosis | Breast cancer            |
| Heart attack        | Angina       | Intestinal cancer        |
| High blood pressure | Alcoholism   | High cholesterol         |
| Hepatitis           | Asthma       | Depression/mood disorder |
| Other _____         |              |                          |

Initial when reviewed \_\_\_\_\_

**Review of Systems** (Place a  $\checkmark$  for any question that pertains to you at this time)

<b>General</b>	Recent change in weight Fatigue Nervousness/anxiety Insomnia	Change in appetite Fever Do you think you have an eating disorder	Have you ever put drugs in your veins Weakness Do you have any risk factors for AIDS Have you ever vomited for weight control		
	What is your desired weight _____				
<b>Skin</b>	Rashes	Lumps	Itching	Change in hair or nails	
<b>Head</b>	Headaches		Head injury		
<b>Eyes</b>	_____ Date of last eye exam	Difficulty with vision	Glasses or contact lenses		
	Pain	Redness	Double vision		
<b>Ears</b>	Decreased hearing	Ringling	Dizziness	Earache	
	Infection	Discharge	Perforation		
<b>Nose &amp; Sinus</b>	Frequent colds		Nasal stuffiness	Nose bleeds	Sinus trouble
<b>Mouth &amp; Throat</b>	_____ Date of last dental exam	Bleeding gums	Sores in mouth	Frequent sore throats	
<b>Neck</b>	Lumps				
<b>Breasts</b>	Lumps	Pain	Nipple discharge		
<b>Respiratory</b>	Cough Asthma	Sputum Bronchitis	Blood in Sputum Pneumonia	Wheezing	
<b>Cardiac</b>	Heart murmur Shortness of breath		High blood pressure Past EKGs or heart test	Chest pain Skipped beats	
<b>GI</b>	Trouble swallowing Change in bowel habits Diarrhea Hernia		Vomiting Blood in stool Use of laxatives	Nausea Black stool Hepatitis	Bulimia Constipation Anorexia
<b>Urinary</b>	Frequency	Urgency	Burning	Urinating at night	
	Blood in urine	Hesitancy	Urinary infections	Stones	
<b>Musculoskeletal</b>	Joint pain		Joint stiffness	Back pain	
<b>Neuro</b>	Fainting		Blackouts	Seizures	
<b>Endocrine</b>	Thyroid Problem Excess thirst		Heat or cold intolerance Excess hunger	Diabetes Excess urination	
<b>Hematologic</b>	Anemia		Have you ever had a blood transfusion	Bleeding trait	
<b>Male</b>	Discharge from penis Testicular pain Do you use condoms every time you have intercourse _____ How often do you examine your testicles for masses		Sores on penis Testicular masses	History of sexually transmitted disease Sex with men	
<b>Female</b>	_____ Age menses began	Menses every _____ days	_____ Days of bleeding	Spotting between periods	
	_____ Date of last menstrual period	vaginal discharge		DES exposure	
	_____ # of pregnancies	History of sexually transmitted diseases		Itching	
	_____ # of deliveries	Are condoms used every time you have intercourse			
	_____ #of abortions (spontaneous or induced)				
	_____ Birth control method	How often do you exam your breasts _____			
	Date of last pap smear _____				