Confidential Medical History Form

Name _____ **Preferred name** _____

Date of birth _____ **Pronouns** _____

First day of last menstrual period: _____

TOBACCO USE:

Do you chew tobacco?
☐ Yes ☐ No

Do you smoke cigarettes?
☐ Yes ☐ No

If yes, how many packs a day?
☐ 0.25 ☐ 0.5 ☐ 1 ☐ 2 ☐ 2.5 ☐ 3

E-cigarettes/vape/Juul?
☐ Yes ☐ No

If yes, cartridges per day?
_____

Start date: _____ **End date:** _____ **Ready to quit?** ☐ Yes ☐ No

Years smoked: _____ **Years vaped:** _____

List your current medications (including birth control, over-the-counter medications, vitamins, etc.):

_____
_____
_____
_____

List your allergies:

_____
_____
_____
_____

Do you want to use the University Health Center Pharmacy? ☐ Yes ☐ No

If no, what is your pharmacy preference?

_____

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

Medical:

☐ ADD/ADHD
☐ Adrenal disorders
☐ Alcohol abuse
☐ Allergies
☐ Anemia
☐ Anorexia
☐ Anxiety
☐ Arthritis
☐ Asthma
☐ Bipolar disorder
☐ Bladder disease
☐ Bleeding disorder
☐ Borderline personality disorder
☐ Bulimia
☐ Cancer
☐ Celiac disease
☐ Chlamydia
☐ Clotting disorder
☐ Concussion
☐ COVID-19
☐ Depression
☐ Diabetes
☐ Eczema
☐ Endometriosis
☐ Eye disorders
☐ Fatigue
☐ Fractures/broken bones
☐ Genital warts
☐ Gonorrhea
☐ Headaches
☐ Hearing loss
☐ Heart disease
☐ Heart murmur
☐ Hepatitis
☐ Herpes
☐ HIV/AIDS
☐ Hives
☐ Human papillomavirus (HPV)
☐ High cholesterol
☐ High blood pressure
☐ Infectious mononucleosis
☐ Irritable bowel syndrome (IBS)
☐ Kidney stones
☐ Malaria
☐ Multiple sclerosis
☐ Mumps
☐ Muscular dystrophy
☐ Obsessive-compulsive disorder (OCD)
☐ Oppositional defiant disorder (ODD)
☐ Paget's disease of bone
☐ Pneumonia
☐ PCOS
☐ Pregnancy
☐ Psoriasis
☐ Post-traumatic stress disorder (PTSD)
☐ Radiation therapy
☐ Schizophrenia
☐ Seizures
☐ Sinusitis (chronic)
☐ Stroke
☐ Thyroid disease
☐ Tuberculosis
☐ Typhoid fever
☐ Ulcerative colitis
☐ Varicella/chicken pox

Anesthesia:

☐ Difficult intubation
☐ Malignant hyperthermia
☐ Postoperative nausea and vomiting (PONV)
☐ Pseudocholinesterase deficiency
☐ Spinal headache

Surgical:

- ☐ Adenoidectomy
- ☐ Appendectomy
- ☐ Gallbladder
- ☐ Ear tubes
- ☐ Knee ACL tear
- ☐ Knee arthroscopy
- ☐ Organ transplant
- ☐ Ovarian cyst removal
- ☐ Splenectomy
- ☐ Tonsillectomy
- ☐ Weight loss surgery
- ☐ Wisdom teeth
- ☐ Other surgical history: _____

FAMILY HISTORY:

	Living	Deceased	Alcohol abuse	Breast cancer	Clotting disorder	Colon cancer	Diabetes	Drug dependency	Heart disease	High blood pressure	High cholesterol	Learning disabilities	Melanoma cancer	Mental illness	Stroke	Sudden cardiac arrest	Other cancer	Other health issues
Mother																		
Father																		
Sister																		
Brother																		
Maternal grandfather																		
Maternal grandmother																		
Paternal grandfather																		
Paternal grandmother																		

- ☐ Adopted
- ☐ Family history unknown

EXERCISE:

Do you exercise regularly?

- ☐ Yes
- ☐ No

I moderately exercise:

- ☐ Less than three times per week
- ☐ Three or more times per week

I strenuously exercise:

- ☐ Less than three times per week
- ☐ Three or more times per week

ABUSE HISTORY: ***As violence is a problem in many families, we ask these questions to ALL patients.*** *Please check all that apply.*

Verbal abuse:

- ☐ Never experienced
- ☐ Experienced in the past
- ☐ Currently experience
- ☐ Choose not to disclose

Physical abuse:

- ☐ Never experienced
- ☐ Experienced in the past
- ☐ Currently experience
- ☐ Choose not to disclose

Sexual abuse:

- ☐ Never experienced
- ☐ Experienced in the past
- ☐ Currently experience
- ☐ Choose not to disclose

ALCOHOL USE:

Do you drink?

☐ Yes ☐ No

If yes, how many per week?

Glasses of wine: _____ Cans of beer: _____ Shots of liquor: _____

How often do you have a drink containing alcohol?

☐ Never ☐ Monthly or less ☐ 2-4 times/month ☐ 2-3 times/week ☐ 4 or more times/week

How many standard drinks containing alcohol do you have on a typical day?

☐ 0-2 ☐ 3-4 ☐ 5-6 ☐ 7-9 ☐ 10 or more

How often do you have 6 or more drinks on one occasion?

☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

SUBSTANCE ABUSE

Do you currently use? ☐ Yes ☐ No **If yes, how many per week?** _____

I use:

☐ Amphetamines	☐ "Crack" cocaine	☐ Hashish	☐ Mescaline	☐ Opiates
☐ Amylnitrate	☐ Cocaine	☐ Ketamine	☐ Methamphetamines	☐ Opium
☐ Anabolic steroids	☐ Fentanyl	☐ LSD	☐ Methaqualone	☐ PCP
☐ Barbiturates	☐ Flunitrazepam	☐ Marijuana	☐ Methylphenidate	☐ Psilocybin
☐ Benzodiazepines	☐ GHB	☐ Ecstasy	☐ Nitrous oxide	☐ Solvent inhalants

☐ Other: _____

SEXUAL ACTIVITY/BIRTH CONTROL

Are you sexually active? ☐ Yes ☐ Not currently ☐ Never **Partners:** ☐ Male ☐ Female ☐ Both

Date of last Pap test: _____ **Was your last Pap test normal?** ☐ Yes ☐ No

Birth control/method of contraception: *(Check all that apply)*

☐ Abstinence	☐ Diaphragm	☐ Patch	☐ Sponge	☐ None
☐ Birth control pills	☐ Implant	☐ Post-menopausal	☐ Surgical	☐ Other: _____
☐ Cervical cap	☐ Injection	☐ Rhythm	☐ Vaginal condom	_____
☐ Condom	☐ IUD	☐ Spermicide	☐ Withdrawal	_____

SEXUAL ORIENTATION/GENDER

What is your sexual orientation?

☐ Straight (not lesbian or gay)	☐ Gay ☐ Lesbian	☐ Bisexual ☐ Don't know	☐ Choose not to disclose	☐ Something else: _____

What is your gender?

☐ Female	☐ Transgender female	☐ Non-binary	☐ Choose not to disclose	☐ Other: _____
☐ Male	☐ Transgender male			

ADVANCED DIRECTIVE: **I have:** ☐ Living will ☐ Durable power of attorney for health care ☐ None

Would you like information about the above? ☐ Yes ☐ No

NUTRITION:

Any unintended weight loss of 10 pounds or more in the last two months? ☐ Yes ☐ No

VACCINE:

Have you ever had a pneumococcal vaccine? ☐ Yes ☐ No

Have you had a flu shot this season? ☐ Yes ☐ No

MOBILITY:

Have you had any recent decline in mobility? ☐ Yes ☐ No

Have you had any recent changes in ability to perform activities of daily living? ☐ Yes ☐ No

Do you have a history of falls? ☐ Yes ☐ No

Assitive devices used: *(Check all that apply)*

☐ Brace LLE	☐ C-collar	☐ Commode	☐ Crutches	☐ Eyeglasses
☐ Brace RLE	☐ Cane	☐ Contacts	☐ Dentures	☐ Other: _____

COGNITIVE/FUNCTIONAL:

Are you deaf or hard of hearing? ☐ Yes ☐ No

Are you blind or have difficulty seeing, even when wearing glasses? ☐ Yes ☐ No

Do you have difficulty concentrating, remembering or making decisions? ☐ Yes ☐ No

Do you have difficulty walking or climbing? ☐ Yes ☐ No

Do you have difficulty dressing or bathing? ☐ Yes ☐ No

Do you have difficulty doing errands alone, such as visiting a doctor's office or shopping? ☐ Yes ☐ No

DEPRESSION SCREENING:

Little interest or pleasure in doing things:

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Feeling down, depressed or hopeless:

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

HOME CARE:

Current type of residence:

☐ Off campus with others ☐ Off campus alone ☐ On campus with others ☐ On campus alone

Support systems: *(Check all that apply)*

☐ Spouse/ significant other ☐ Parent ☐ Children ☐ Family members ☐ Case manager/ social worker ☐ Church/faith community ☐ Friends/ neighbors

☐ Home care staff ☐ Organized support group ☐ Shelter ☐ Therapist ☐ None ☐ Other: _____

CURRENT ASSISTANCE AT HOME: any outside assistance you receive at home *(Check all that apply)*

☐ None ☐ Rehab ☐ Medications ☐ Activities for daily living (ADLs) ☐ Other _____

☐ Supervised setting ☐ Educational support ☐ Respiratory care _____

☐ Home health care ☐ Equipment ☐ In home care giver _____

Home care services? ☐ Yes ☐ No

HEALTH LITERACY SCREENING: comfort with medical information

How often do you have someone help you read health or medical material?

☐ Never ☐ Occasionally ☐ Sometimes ☐ Often ☐ Always

How often do you have problems learning about your medical condition because of difficulty understanding written information?

☐ Never ☐ Occasionally ☐ Sometimes ☐ Often ☐ Always

How often do you have a problem understanding what is told to you about your health or medical condition?

☐ Never ☐ Occasionally ☐ Sometimes ☐ Often ☐ Always

How confident are you filling out health or medical forms by yourself?

☐ Extremely ☐ Quite a bit ☐ Somewhat ☐ A little bit ☐ Not at all

LEARNING QUESTIONNAIRE:

Do you have learning and/or communication barriers? *(Check all that apply)*

☐ No barriers ☐ Language ☐ Hearing ☐ Emotional ☐ Financial

☐ Reading ☐ Visual ☐ Physical ☐ Cognitive ☐ Other:

What is your preferred language for education material? *(Check all that apply)*

☐ English ☐ Chinese ☐ Vietnamese ☐ Arabic ☐ Other: _____

☐ Spanish ☐ Japanese ☐ Russian ☐ Hmong _____

Do you need an interpreter? ☐ Yes ☐ No **If yes, what language is needed?** _____

Are you ready to learn about your health and plan of care?

☐ Yes ☐ No

Do you have any cultural or religious beliefs that may impact education and learning?

☐ Yes ☐ No

What is the best way for you to learn? *(Check all that apply)*

☐ Listening ☐ Reading ☐ Demonstrations ☐ Videos/pictures ☐ Other: _____

_____