

**UNIVERSITY OF MARYLAND
UNIVERSITY HEALTH CENTER
Health History**

Name: _____ University ID Number: _____ Date: _____ Age: _____
 Phone #: _____ Marital Status: _____ Date of birth: _____
 Local Address: _____ City, State, Zip: _____
 Drug Allergies: _____ List Medicines taking: _____
 Reason for today's visit: _____

Family History: Adopted

List anyone in your family (parents, grandparents, or siblings) who have had:

No	Yes	Unsure		No	Yes	Unsure	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Breast Cancer _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Strokes and Blood clots _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack before 50 _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Birth Defects/Genetic Traits: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other Heart Disease: _____				

Personal History: Have you ever had the following; if you check yes, please explain.

No	Yes	Unsure		No	Yes	Unsure	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Birth Defects/Disabilities _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Back, muscle, or joint problems _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Serious Illness _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Surgery _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease (Hepatitis, Mononucleosis, Jaundice) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gall Bladder Disease _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hospitalization _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stomach or Intestine Problems _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headaches: Tension/Stress, migraines, or Sinus/allergy Problems _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Urinary/Bladder/Kidney _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/Seizures/Convulsions _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Immune System Problems _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease/murmur/Rheumatic fever, or High blood pressure _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Strokes/Blood Clots _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lung Problems, TB, Asthma _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood problems (anemia, clotting, problems, Sickle Cell, etc.) _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you participate in a regular exercise program? _____				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric/emotional problems or depression _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you smoke? How much/day? _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Concerns about your weight /eating habits? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol use? How much/wk? _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Acne (list meds) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Drug use? _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hormone Problems including hirsutism (excess hair) _____				Marijuana, cocaine, Adderall, Oxycontin, LSD/shrooms, other? _____

Please complete the reverse side

Sexual Health History:

No Yes Unsure

Have you had intercourse? No Yes

Age at first intercourse: _____

Number of partners in the last year _____

Partner(s) Male Female Both _____

Do you use condoms for STD/STI prevention? Always Sometimes Never

Have any questions/concerns about STIs? _____

Sexually Transmitted Infections (STIs):
Gonorrhea, Syphilis, Genital Herpes, HIV.
Chlamydia, Genital Warts, Trichomonas,
Hepatitis B or c, HPV, other: _____

At the University Health Center we are concerned about the issue of abuse. These questions are provided so we can offer help to those who need assistance. Your response is voluntary.

Have you ever been emotionally or physically abused by your partner or someone important to you? No Yes

Has anyone ever forced you to have sexual activities? No Yes

Are you afraid of your partner or anyone else? No Yes

Are there any areas of health or well-being you would like to discuss? _____

The information provided is accurate to the best of my knowledge.

Signature _____ Date _____

Female Patients Only

Menstrual History:

First day of last menstrual period _____

Was this period normal? No Yes

Do you think you might be pregnant now? No Yes Maybe

Age periods began _____

Periods come every _____ days

Number of days of menstrual flow _____

Are periods Light Moderate Heavy

Have you ever:

No Yes

Missed periods

Had bleeding in between periods

Had pain with periods (menstrual cramps)

Take medicine for pain _____

Had other premenstrual symptoms? _____

Gyn History:

No Yes Unsure

Is this your first pelvic exam? If no, date of last exam _____

Breast problems (lumps, tumors, discharge, cysts) _____

Vaginal infections _____

Pelvic infections (uterus, tubes, ovaries, or PID) _____

Other problems with ovaries, uterus, tubes (fibroids, tubal pregnancy) _____

Pain or bleeding with intercourse _____

Abnormal Pap Smear(s)? Dates _____

Treatment for abnormal pap smears _____

Contraceptive History:

Have you or your partner ever used birth control? No Yes

Oral Contraceptives (Pill) Depo Provera Morning After Pill Diaphragm Condoms

Spermicide Norplant\ Cervical Cap Natural Family Planning

IUD Nuva Ring Ortho Evra (Patch) Other

List any problems with these methods: _____

Are you using birth control now? No Yes Type _____

Do you desire birth control today? No Yes Type _____ Unsure of type I want

Pregnancy History:

Have you ever been pregnant? No Yes

Age at first pregnancy _____ Number of pregnancies _____ Number of abortions _____

Number of live births _____ Number of living children _____ Number of miscarriages _____

