### ASU HEALTH SERVICES

#### HEALTH HISTORY

**I AM AT ASU HEALTH SERVICES TODAY BECAUSE:**

<table>
<thead>
<tr>
<th>PERSONAL MEDICAL HISTORY</th>
<th>Date diagnosed (month-year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABNORMAL PAP SMEAR</td>
<td></td>
</tr>
<tr>
<td>ACNE</td>
<td></td>
</tr>
<tr>
<td>ALLERGIES / HAY FEVER</td>
<td></td>
</tr>
<tr>
<td>ANEMIA</td>
<td></td>
</tr>
<tr>
<td>ANOREXIA/BULIMIA</td>
<td></td>
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<tr>
<td>ARTHRITIS</td>
<td></td>
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<tr>
<td>ASTHMA</td>
<td></td>
</tr>
<tr>
<td>BACK PROBLEMS</td>
<td></td>
</tr>
<tr>
<td>BLEEDING DISORDER</td>
<td></td>
</tr>
<tr>
<td>BLOOD CLOTS / PHLEBITIS</td>
<td></td>
</tr>
<tr>
<td>CANCER</td>
<td></td>
</tr>
<tr>
<td>CHOLESTEROL / TRIGLYCERIDE</td>
<td></td>
</tr>
<tr>
<td>CHRONIC KIDNEY CONDITION</td>
<td></td>
</tr>
<tr>
<td>COLITIS ULCERATIVE/GROHN'S</td>
<td></td>
</tr>
<tr>
<td>DEPRESSION</td>
<td></td>
</tr>
<tr>
<td>DIABETES MELLITIS</td>
<td></td>
</tr>
<tr>
<td>EPILEPSY</td>
<td></td>
</tr>
<tr>
<td>HEADACHE - MIGRAINE</td>
<td></td>
</tr>
<tr>
<td>HEADACHE - TENSION</td>
<td></td>
</tr>
<tr>
<td>HIGH BLOOD PRESSURE</td>
<td></td>
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<tr>
<td>KIDNEY STONES</td>
<td></td>
</tr>
<tr>
<td>LIVER DISEASES</td>
<td></td>
</tr>
<tr>
<td>MONOPHYAL SYNDROME</td>
<td></td>
</tr>
<tr>
<td>PREMENSTRUAL SYNDROME</td>
<td></td>
</tr>
<tr>
<td>THYROID PROBLEMS</td>
<td></td>
</tr>
<tr>
<td>OTHER MEDICAL ISSUES</td>
<td></td>
</tr>
</tbody>
</table>

**FAMILY MEDICAL HISTORY**

Please fill out the info below

- Mom
- Dad
- Sister
- Brother
- Other Relative

- Alive and Healthy:
- No Problems
- No info/I don't know
- Alcoholism
- Allergies (Nasal)
- Anxiety
- Asthma
- Blood Clots/DVT
- Cancer
- Type:
- Cholesterol (high)
- Collitis
- Depression
- Diabetes
- Drug Problems
- Epilepsy/Seizures
- Heart Attack/MI
- High Blood Pressure
- Hypertension (high)
- Hypothyroidism (low)
- Kidney Disease
- Liver Disease
- Migraines
- Obesity
- Stroke
- Other Diseases

**ALLERGIES**

<table>
<thead>
<tr>
<th>Medications</th>
<th>Name of Medication</th>
<th>Reaction (rash, upset stomach)</th>
</tr>
</thead>
</table>

**IMMUNIZATIONS**

(if known)

<table>
<thead>
<tr>
<th></th>
<th># of shots needed</th>
<th>Shot #1</th>
<th>Shot #2</th>
<th>Shot #3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chicken Pox</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gardasil (HPV)</td>
<td>3 (0, 2m, 6m)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis A</td>
<td>2 (0, 1m)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>3 (0, 1m, 6m)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Twinrix Hep A&amp;B</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tdap</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meningococcus</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>To skin test PPD</td>
<td></td>
<td>at risk individuals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**CURRENT MEDICATIONS-NAME, DOSE, HOW OFTEN**

**SURGERIES/OPERATIONS/INJURIES**

| month/year | |
|------------||

**TURN PAGE OVER**
**Social History** For care provider to determine health risk

**Primary Language Spoken**
- [ ] English
- [ ] Spanish
- [ ] Other: __________________________

**I live with:**
- [ ] Self (no roommate)
- [ ] Roommates
- [ ] Family members (spouse, parents, siblings)
- [ ] Other: __________________________

**Sexual History**
- [ ] No previous sexual history (skip to next section)
- [ ] Opposite Sex (male with female, female with male)
- [ ] Same Sex (male with male, female with female)
- [ ] Bisexual

# of current partners: __________________________

# of lifetime partners: __________________________

Age at first intercourse: __________________________
(used for female PAP testing)

Hx of sexually transmitted infection (STI's)
- [ ] None
- [ ] Yes
  - [ ] If yes: __________________________

**Use of condoms to protect against STI's**
- [ ] Always
- [ ] Sometimes
- [ ] Never

**Birth Control Method**
- [ ] Abstinence
- [ ] Withdrawal
- [ ] Condoms
- [ ] Oral Contraceptive Pills
- [ ] IUD
- [ ] Other: __________________________

**Drug Use** confidential to be used by your health care provider to determine health risk.

- [ ] None
- [ ] Yes - Please list __________________________

**Alcohol Use**
- [ ] None
- [ ] Yes - How many do you drink? __________________________ mixed drink with 1 shot of liquor)

**circle one** rarely < once/week 2-3x/week occasionally once a week daily

Do you usually drink more than 5 drinks at one time? [ ] Yes [ ] No

- [ ] Former use - date quit: __________________________

**Wellness Questions - Check box for all positive responses**

- Are you so stressed that it interferes with schoolwork or job?
  - Over the past two weeks, have you had little interest or pleasure in doing things more than 1/2 of the days?
  - Over the past two weeks, have you felt down, depressed, or hopeless more than 1/2 of the days?
  - Does someone make you feel unsafe in your house (eg verbally, sexually or physically abused)?
  - Are you currently considering hurting yourself or suicide?
  - Are you currently considering hurting or killing someone else?
  - Have you used laxatives or vomited to control your weight?
  - Are you concerned that you need to lose weight?
  - Do you want to see the dietician at CHS to go over a healthy diet?
  - Do you use a tanning bed or sunbathe without use of sunscreen?

**Nursing Immediate referral to:**
- [ ] Nursing staff member
  - __________________________
  - __________________________
- [ ] Other: __________________________

**Patient Signature** Date __________________________

**REVIEWING NURSING STAFF MEMBER SIGNATURE** Date __________________________

**REVIEWING CLINICIAN SIGNATURE** Date __________________________