Middle Georgia State University Health Clinic

PERSONAL HEALTH HISTORY

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Name: _____ **Date:** _____
Last ***First*** ***Middle***

Date of Birth: (mm/dd/yyyy) _____ **MGA ID#:** _____

Gender: ❑ Female ❑ Male **Race:** ❑ White ❑ Black ❑ Asian ❑ American Indian ❑ Hawaiian
Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino
Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

DRUG , ALLERGIES OR SENSITIVITIES

❑ **None** ❑ Aspirin ❑ Codeine ❑ Penicillin ❑ Sulfa ❑ Any other drug: _____
Reactions: _____
❑ Environmental: _____ ❑ Stings (bee, hornet, etc.) _____ ❑ Food _____

MEDICATIONS

Medication	Strength	Dosage	Frequency

ILLNESS/INJURY/CONDITIONS

☐ None	☐ Diabetes	☐ Irregular Heart Beat	☐ Strain/Sprain
☐ ADD/ADHD	☐ Dislocation of joints	☐ Irritable Bowel syndrome	☐ Substance Abuse
☐ **Anemia**	☐ Eating disorders	☐ Kidney Disease	☐ Surgery*
☐ **Anxiety/Panic attacks**	☐ Fracture	☐ Leukemia	☐ Tendonitis
☐ **Arthritis**	☐ Gallbladder/ Liver disease	☐ Mono	☐ Thyroid/Endocrine Disturbance
☐ **Asthma**	☐ Hearing problems	☐ Pneumonia	☐ Tonsillitis
☐ **Bleeding trait**	☐ Heart disease	☐ Scarlet Fever	☐ Tuberculosis
☐ **Blindness**	☐ Heart murmur	☐ Seizures or Epilepsy	☐ Varicose Veins
☐ **Cancer or Malignancy**	☐ Heat Exhaustion or Intolerance	☐ Severe Headaches Migraine	☐ Wear any type of brace
☐ **Chronic skin disease**	☐ Hepatitis Type: _____	☐ Shortness of breath	☐ Wear Dental appliance
☐ **Colitis/IBD**	☐ Hernia	☐ Sickle Cell Anemia	☐ Wear Contacts
☐ **Concussion**	☐ High Blood Pressure	☐ Sleep disorder	☐ Wear Glasses
☐ **Congenital heart Defect or Rheumatic heart**	☐ HIV	☐ Speech	☐ Other
☐ **Depression**	☐ Hospitalization*	☐ Stomach or Ulcer disorder	☐ Other

*Explain:_____
_____
_____

(Please list if there's a family (i.e. grandparents, parents, and siblings) history of illness, etc.
❑ Tuberculosis ❑ Anemia ❑ Heart attack ❑ High blood pressure ❑ Diabetes ❑ Cancer
❑ Sudden unexplained deaths ❑ Substance Abuse ❑ Other serious illnesses, please specify:
_____

FEMALES

☐ **Menstrual Difficulties** ☐ Date of Last menstrual cycle _____

☐ **Missed cycle: Yes** _____ **No** _____

☐ **Sexually Transmitted Diseases** ☐ Pregnancy concerns

MALES

☐ Absence of testicle or other paired organ
☐ Sexually Transmitted Diseases

HABITS

❑ None
❑ Alcohol quantity/week _____ ❑ Tobacco quantity/day _____
❑ Marijuana quantity/week _____ ❑ Cocaine quantity/week _____
❑ Caffeine quantity/day _____ ❑ Recreation Drugs/week_____

❑ Yes ❑ No Are you currently under a doctor's care for these or any other condition?
If YES please provide the following information:

Nature of condition: _____
_____

TREATING PHYSICIAN Name:_____ Phone: (____)_____
Address (city, state, zip): _____ Fax: (____)_____

Is your general Health ❑ Excellent? ❑ Good? ❑ Fair? ❑ Poor?

By signing below, I certify the information I have provided is complete and true to the best of my knowledge.

_____ _____
Patient Signature **Date**