Middle Georgia State University Health Clinic

PERSONAL HEALTH HISTORY

Legal Name: ____ Date: _______
Last, First Middle
Preferred Name: _______________________ ____________________________

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

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Other

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

❑ **No medical history or major illness/injury**
❑ Wear glasses
❑ Wear contacts
❑ Wear braces/dental appliance

CIRCULATORY
❑ Heart Disease
❑ Heart Defect
❑ Heart Murmur
❑ Irregular Heart Beat
❑ High Blood Pressure
❑ Diabetes

RESPIRATORY
❑ Asthma
❑ Pneumonia
❑ Shortness of Breath
❑ COPD
❑ Sleep Apnea

MUSCULOSKELETAL
❑ Fracture
❑ Arthritis
❑ Tendonitis
❑ Chronic strain/sprain
❑ Wear a brace/splint

NEUROLOGIC
❑ Migraine Headaches
❑ Concussion
❑ Stroke
❑ Fainting/Vertigo
❑ Seizures/Epilepsy
❑ Vision Problems
❑ Hearing Problems
❑ Sleep Disorder
❑ Speech Disorder
❑ ADD/ADHD

ENDOCRINE/METABOLIC
❑ Diabetes
❑ Kidney Disease
❑ Endocrine Problems
❑ Thyroid Disease (hyper/hypo?)
❑ Obesity

GASTROINTESTINAL
❑ Chronic Constipation
❑ Chronic Diarrhea
❑ Stomach Ulcer
❑ Reflux/GERD
❑ Colitis / IBD
❑ Irritable Bowel Syndrome
❑ Hernia
❑ Eating Disorders
❑ Gallbladder Disease
❑ Liver Disease/Hepatitis

HEMATOLOGY
❑ Anemia
❑ Sickle Cell Trait
❑ Sickle Cell Disease
❑ Bleeding trait
❑ Leukemia

OTHER
❑ Cancer or Malignancy
❑ Tuberculosis

MENTAL HEALTH
❑ Anxiety
❑ Depression
❑ Panic Attacks
❑ Insomnia

SKIN
❑ Acne
❑ Eczema
❑ Psoriasis
❑ Skin Cancer
❑ Chronic skin disease

GENITOURINARY
❑ Incontinence
❑ Kidney Stones
❑ Kidney Disease
❑ Frequent UTI or bladder/kidney infection

STIS
❑ HIV
❑ AIDS
❑ Syphillis
❑ Herpes
❑ Chlamydia/Gonorrhea/Trich

COMMUNICABLE DISEASE
❑ Covid-19
❑ Mononucleosis
❑ Recurrent Tonsillitis or Strep throat
❑ Scarlet Fever

***Please include any other health history not listed:** ______________________________
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Do you have any concerns today of harming yourself or others? Yes / No
Please notify provider if you have concerns or need information on local care options

SURGERY OR HOSPITALIZATION

Surgery/Medical Procedure	**Date** (approximate if unknown)	**Concerns or Complications** (circle)	**Full Recovery** (circle)
		YES / NO	YES / NO
		YES / NO	YES / NO

FAMILY HISTORY OF ILLNESSES

Please list known health history/illness of close relatives (parents/siblings/grandparents):
❑ Tuberculosis ❑ Anemia ❑ Heart attack ❑ High blood pressure ❑ Diabetes ❑ Cancer
❑ Sudden unexplained deaths ❑ Substance Abuse ❑ Other serious illnesses, please specify:____

FEMALES

❑ Date of **most recent menstrual cycle** (or start date of current cycle) _______________
❑ Difficulty with cycles ❑ Irregular cycles ❑ Pregnancy concerns ❑ Missed cycle **Yes / No**
❑ Previous pregnancy **Yes / No** ❑ Previous miscarriage/loss **Yes / No** ❑ Previous termination **Yes / No**

IMMUNIZATIONS

❑ Measles ❑ Mumps ❑ Rubella ❑ MMR ❑ Varicella ❑ Hepatitis B series (3 injections)
❑ Meningitis ❑ Meningitis B ❑ Gardasil (HPV 2-3 injections) ❑ Polio
❑ Tetanus-Diphtheria (Tdap) or Tetanus Booster Last dose: _____/_____/_____
❑ Tuberculosis Skin Test **(**PPD) Last Tested: _____/_____/_____ ❑ Negative ❑ Positive
❑ Influenza (seasonal flu) __❑ Covid-19 (circle: Moderna / Pfizer / J&J / Novavax / Other)
*** Please notify provider if you have questions or are interested in vaccination***

SUBSTANCE USE

❑ None
❑ Alcohol quantity/week ________________ ❑ Tobacco quantity/day ________________
❑ Marijuana quantity/week ______________ ❑ Cocaine quantity/week _______________
❑ Caffeine (more than 2 cups of coffee/day): Yes / No ______________
❑ Recreational/Street/Party/Other Drugs: Yes / No
❑ Narcotics/Opioids or Prescription Drugs NOT prescribed to you: Yes / No

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Do you have a primary care provider either locally or in your hometown? ❑ Yes ❑ No
If **YES** please provide the following information:

Provider/Doctor/Office Name: ____________________________ Phone: (_____)__________
Are you being treated for a particular condition/diagnosis? __________________
Approximate date of last health visit or physical exam (month/year):
____
Please notify provider if you would like information on local health care options

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

____ ____________________________

Patient Signature **Date**