# Middle Georgia State University Health Clinic

## PERSONAL HEALTH HISTORY

**0**

**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_____

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☐ 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: (____)_____

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**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**