Marquette University Medical Clinic
Health History Form

Past Medical History
Please check box and briefly explain if you have been diagnosed with any of the following:

☐ Allergies___________________________________________
☐ Anxiety___________________________________________
☐ Asthma____________________________________________
☐ Depression________________________________________
☐ Diabetes (type I or II)______________________________
☐ Eating disorder____________________________________
☐ Heart condition(eg; murmur)________________________
☐ High Blood Pressure_______________________________
☐ Menstrual disorder (irregular, amenorrhea, cramps)____
☐ Thyroid disease____________________________________
☐ Other problem(s) not listed________________________

Please list any hospitalizations, significant injuries, or surgeries:
___________________________________________________________________________

Social History
How often do you have a drink with alcohol?
☐ Never ☐ ≤once a month ☐ 2-4 times a month ☐ 2-3 times a week ☐ ≥4 times a week
How many drinks at a time?
☐ Never ☐ < Monthly ☐ Monthly ☐ Weekly ☐ Daily
How often do you have: more than 4 drinks (for women) or more than 5 drinks (for men)
☐ Never ☐ < Monthly ☐ Monthly ☐ Weekly ☐ Daily
Is alcohol a concern for you or others? ___ yes ___ no
Do you use tobacco? ___ yes ___ no Are you interested in quitting? ___ yes ___ no

Are you Sexually Active? ___ yes ___ never ___ not currently Number of partners in lifetime____
Have you ever had any sexually transmitted diseases? ___ yes ___ no
Are you interested in being screened for STDs? ___ yes ___ no

Have you been hit, kicked, punched, or otherwise hurt by someone in the past year? ___ yes ___ no
If so, by whom? _________________________________
Do you feel safe in your current relationship? ___ yes ___ no
Is there a partner from a previous relationship making you feel unsafe now? ___ yes ___ no

During the past month:
Have you often been bothered by feeling down, depressed, or hopeless? ___ yes ___ no
Have you often been bothered by little interest in pleasure in doing things? ___ yes ___ no

Please list all medications you take regularly (include birth control pills, non-prescription drugs,
vitamins, herbal supplements)___________________________________________________________________________

Please list any medication allergies______________________________________________________________

Family History
Please check box if any family members (parents, siblings, grandparents, aunts or uncles) have been
diagnosed with any of the following conditions:

☐ Heart disease ☐ High Cholesterol ☐ Diabetes ☐ Tuberculosis
☐ High Blood Pressure ☐ Stroke ☐ Alcoholism ☐ Depression
☐ Other mental illness ☐ Cancer (type)________________________

Women's Health History
First day of last period __________ Age periods began _______
Number of periods in last 12 months ________ Date of last PAP smear/pelvic exam __________
☐ Normal ☐ Abnormal
Have you ever had an abnormal PAP smear? ________________________________

SKO 5/21/13
For Staff Use Only

Review of Systems

**General:**
- □ No fever, chills, weight change
- □ Other
- □ No rash, itching
- □ Other

**Skin:**
- □ No rash, itching
- □ Other

**HEENT:**
- □ No vision change, headache, hearing problems, dysphagia
- □ Other

**Breast:**
- □ No masses or discharge
- □ Other

**Resp:**
- □ No dyspnea, cough
- □ Other

**Cardiovascular:**
- □ No chest pain, edema, or easy bleeding
- □ Other

**GI:**
- □ No nausea, vomiting, diarrhea, constipation
- □ Other

**Urinary:**
- □ No dysuria, frequency
- □ Other

**Genital:**
- □ No discharge or sores
- □ Other

**Musculoskel:**
- □ No muscle or bone pain
- □ Other

**Neuro:**
- □ No numbness or tingling
- □ Other

**Endo:**
- □ No hot or cold intolerance
- □ Other

**Psych:**
- □ No anxiety or depression
- □ Other

Physical Examination

**Ht:** ________    **Wt:** ________    **BMI:** ________    **Temp:** ________    **Resp:** ________    **BP:** ________    **Pulse:** ________

<table>
<thead>
<tr>
<th>Normal</th>
<th>Abnormal</th>
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| **General Appearance:**
- □ Normal appearance, NAD. | □______________ |
| **HEENT:**
- □ NCAT. EOMI. PERRL. TM/OP clr | □______________ |
| **Neck:**
- □ No LAD or thyromegaly. Supple. | □______________ |
| **CV:**
- □ RRR. No m/g/c/r. Pulses intact. | □______________ |
| **Lung:**
- □ CTAB. No wheeze, ronchi, rale. | □______________ |
| **Abdominal:**
- □ Soft, NT, ND. No HSM. | □______________ |
| **Skin:**
- □ No scars, rash or bruise. | □______________ |
| **Musculoskeletal:**
- □ FROM. Non tender extremities | □______________ |
| **Neuro:**
- □ Reflexes intact. No focal deficits. | □______________ |

**Labs:** __________________________________________________________________________

**Assessment:**
- □ Student is in good health and free of any communicable disease

**Plan/Recommendations:**

**Physician/Provider Name:** ___________________________    **Date:** ___________________________

**Physician/Provider Signature:** ___________________________

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