RRCC STUDENT HEALTH CLINIC **TODAY'S DATE**_____

Patient Name: **Age:** **Sex:** **Gender:**

Medical History Form

PAST MEDICAL HISTORY: ex: diabetes, gallstones, high blood pressure, etc…	
1.	**4.**
2.	**5.**
3.	**6.**

PAST SURGICAL HISTORY: ex: ACL repair, heart valve replaced, appendix removed, C-section	
1.	**4.**
2.	**5.**
3.	**6.**

MEDICATION ALLERGIES: What happens when you take that medicine:	**OTHER ALLERGIES**: (such as bees/wasps, foods, latex, etc) What happens when you are exposed:

Current **MEDICATIONS**: Prescription and Non-Prescription (including aspirin, vitamins, birth control, herbs, supplements, etc.)

SOCIAL HISTORY:	
Married: Y N Partner Sig Other	Children:
Your Occupation:	Employed: Y N Where:
In school for:	Hobbies:

Recent Significant Changes/ Stresses in Your Life? Yes No explain:

Have you used any of the following substances?

Substance?	**Currently Use?**	**Previously Used?**	**Type/Amount/Frequency**	**How Long?** (Years)	**If stopped, when?** (Year)
Caffeine: coffee, tea, soda					
Tobacco					
Alcohol: beer, wine, liquor					
Recreational/Street Drugs					
Prescription Drug Abuse					

Second Hand Smoke: Have you <u>ever **regularly**</u> been exposed to secondhand smoke? Yes__ No__ if yes, #of years___

Patient Name:

FAMILY HISTORY						
Please check any family members who have the following health problems.						
	Father	**Mother**	**Brother**	**Sister**	**Grandparent**	**SELF**
Diabetes						
Glaucoma						
Cancer (List type)						
Heart attack						
Sudden Death						
Stroke						
High blood pressure						
High cholesterol						
Alcoholism						
Drug Abuse						
Depression						
Mental illness (please describe)						
Suicide						
Other health problems (please list)						

CURRENT HEALTH PRACTICES	
Food, exercise, and safety can all play a role in your health.	
Do you exercise regularly? Y N Type of exercise and frequency:	
List any nutrition or diet concerns you would like help with:	
If you are on a **special diet**, please explain:	
Do you have regular **Dental** check-ups? Y__ N__ How often do you brush/day____ floss___	
Do you wear your seatbelt: Always___ Sometimes___ Never___	
Do you ride a motorcycle? Y__ N__ Bicycle? Y__ N__ Ski/Snowboard? Y__ N__ Skateboard? Y__ N__ If yes, do you wear a **helmet**? Y__ N____	
Do you have a **smoke detector** in the home: Y__ N__	When was it last checked?

Patient Name:

REVIEW OF SYSTEMS:

If you are experiencing any of the symptoms below, please check the box, if not, you may leave it blank.

GENERAL:	Recent unintended Weight Change	Significant or Unusual Fatigue
BREASTS: Men & Women	Lumps/Tenderness	Do You Do Monthly Self Breast Exams? Y__N__
	Drainage from Nipple	Month and Year of Last Mammogram:_____
EYE, EAR, NOSE, AND THROAT		
Hearing Loss	Use Glasses or Contact Lenses	History of Radiation Therapy to Head / Neck
CARDIOPULMONARY	Abnormal Shortness Of Breath	Heart Palpitations
	Chest Pain	Wheezing
GASTROINTESTINAL:	Heartburn	Abdominal Pain
	Blood in Stool/Black Stool	
NEUROPSYCHIATRIC	Frequent Disabling Headaches	Often Feel Sad or Depressed
	Frequent Anxiety or Anxiety Attacks	

Treated in Past for Emotional or Psychological Problems: please describe

SKIN Mole that has changed color, size, shape, or won't heal? Yes No

GENITOURINARY: History of Multiple Sex Partners History of Kidney or Bladder Stones

Method of Birth Control: _____

Have you ever had any Sexually Transmitted Diseases: Yes___ No___
if yes, please describe:

MEN ONLY Pain or Lump in Testicles/Scrotum Do you do monthly Self Testicular Exam: Yes___ No ___

WOMEN ONLY

Age of First Period:	Frequency/Length of Menstrual Periods:
Date of Last Menstrual Period:	Change in Menstrual Pattern: Y N
Number of Pregnancies:	Number of Children:
Disabling Menstrual Cramps: Y N	Unusual Vaginal Discharge/Itching: Y N
Date of Last Pap Smear:	Heavy menstrual flow: Y N
History of Abnormal Pap Smear: Y N	Any Treatments for Abnormal Pap:

To the best of my knowledge, this is an accurate statement of my health:

Signature:_____ Date: _____