Health Center
at Touro University Nevada

Name: _____ DOB: _____

Circle any you may have or have had:

Arthritis	Drug & Alcohol Abuse	Miscarriages
Asthma	Heart Disease	Pneumonia
Bleeding Tendency	Hepatitis (B,C)	Scoliosis
Blood Transfusions	High Cholesterol	Skin Disease
Cancer	HIV	Stroke
Cataract	Hypertension	Tuberculosis
COPD	Kidney Disease	Ulcers
Diabetes	Mental Illness (Depression/Anxiety)	Sexually transmitted disease
Blood Clot	Osteoporosis	
Thyroid disease		

Explain any circled items or add any other problems you may have had.

_____
_____
_____
_____

FAMILY HISTORY: *(List any diseases by family member (i.e. hypertension, diabetes, heart attack, stroke or cancer)*

Relative / Relationship **Illness/Medical Condition**

Mother_____
_____

Father_____
_____

CURRENT MEDICATIONS: *(prescription and over the counter)*

Name **Strength** **Frequency**

_____
_____
_____
_____
_____
_____

If you have any further medications, please list them on the back of this form.

ALLERGIES (*Medications, foods, etc. and list the reaction***)**

_____
_____
_____

SURGICAL HISTORY

Year	Operation	Reason for Surgery	Hospital/Location

SOCIAL HISTORY

Do you smoke?_____ How much per day?_____ How many years?_____
Do you drink alcohol? _____
Do you use any narcotics or addicting medications?_____
Do you use caffeine (coffee, soda, tea?)_____
What is your marital status? Circle One:
Single Married Divorced Separated Widowed Partner
What is your occupation? _____
Are you in danger either from yourself or someone else? ____ Yes ____ No

PREVENTIVE CARE

When was the last time you had each of the following? (circle if it was normal or abnormal)

Pap Smear? _____ Normal /Abnormal
Mammogram? _____ Normal /Abnormal
Bone Density Scan?_____ Normal /Abnormal
Colonoscopy?_____ Normal /Abnormal
Cholesterol check?_____ Normal /Abnormal
Prostate exam?_____ Normal /Abnormal
EKG?_____ Normal /Abnormal
Chest Xray?_____ Normal /Abnormal

IMMUNIZATIONS

Tetanus shot? ____Yes ____No _____Date
Pneumonia? ____Yes ____No _____Date
Flu? ____Yes ____No _____Date
Shingles? ____Yes ____No _____Date

PREGNANCY HISTORY

How many pregnancy's?_____
How many were? Live Birth_____ Miscarriage_____
Termination_____ Tubal_____

Please list all other physician's names, address, phone number and fax number that you currently see.

_____
_____
_____
_____