



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.

