CAMPUS HEALTH CENTER | 5200 Anthony Wayne Drive, Suite 115, Detroit, MI 48202 | (313) 577-5041

MEDICAL HISTORY FORM

Internal Use Only:
MCIR: ☐Yes ☐No

Name: ______________________________ DOB: ______________
First Middle Initial Last MM / DD / YY

PAST HEALTH HISTORY		
Have you ever had any the following:	**YES**	**NO**
Asthma		
Diabetes		
Hay Fever		
Headaches		
High Blood Pressure		
Infectious Mono		
Frequent Anxiety		
Frequent Depression		
Suicidal Thoughts		
Pneumonia		
Menstrual Problems		
Pregnancy		
Seizures		
Sickle Cell Anemia		
Sexually Transmitted Diseases If yes, specify: ______________________		
Other:______________________________		

SURGICAL HISTORY	**YES**	**NO**
Have you ever had surgery? If yes, what kind? ____________________ When did you have this surgery? __________		

FAMILY MEDICAL HISTORY *Please mark if paternal/maternal

Check all that apply:	Fa	Mo	Sis	Bro	Gma	Gpa
Healthy						
Health Unknown						
Deceased						
Allergies						
Asthma						
Cancer						
Depression						
Diabetes						
Heart Attack <40 Yrs						
Heart Disease						
High Blood Pressure						
Stroke						
Substance Abuse						
Domestic Violence						
Other:						

ALCOHOL USE	**YES**	**NO**
Do you drink alcohol? How often? ________ How much? _______		

DRUG USE	**YES**	**NO**
Do you ever use recreational drugs? What kind? ________________________ How often? ________________________		

SOCIAL HISTORY	**YES**	**NO**
Have you ever been emotionally ____, physically ____, or sexually ____ abused?		
Do you feel safe at home? At school? If yes, please circle.		
Are you concerned about violence or abuse at home? With others? If yes, please circle.		

SEXUAL HEALTH	**YES**	**NO**
Do you have sex with: Men:____ Women:____ Both:____ N/A:___		
How many partners have you had in the last 12 months? _______ 2 months? ______		
Do you give/receive oral sex? (circle) Condoms: Never__ Sometimes__ Always__		
Do you give/receive vaginal sex? (circle) Condoms: Never__ Sometimes__ Always__		
Do you give/receive anal sex? (circle) Condoms: Never__ Sometimes__ Always__		

MEDICATIONS	**YES**	**NO**
Do you have allergies to any medications? Please list: ______________________		
Are you currently taking any medications? (Including prescriptions, over the counter drugs, and birth control) Please list: ______________________ ______________________ ______________________		

PREFERRED PHARMACY INFORMATION

*This is where we will send your prescriptions at the end of your visit (if applicable)

Name: ______________________________

Address: ______________________________

____

Phone:______________________________

FOR PHYSICAL/CLEARANCE EXAMS ONLY

Circle all symptoms that apply in each category. If applicable, please **explain** answers in the provided area.

GENERAL
Loss of appetite, chills, dizziness, fatigue, fever, headache, night sweats, sleep disturbance
Explain: ______________________________
____

EYES
Blurry vision, double vision, loss of vision, discharge, swelling
Date of last eye exam: ____________________
Explain: ______________________________
____

EARS, NOSE & THROAT
Earache, decreased hearing, nasal congestion, sore throat, hoarseness
Date of last dental exam: ____________________
Explain: ______________________________
____

HEART
Chest pain, fast or slow pulse, feeling faint, swelling in feet, elevated blood pressure
Explain: ______________________________
____

LUNGS & BREAST
Cough, shortness of breath, wheezing, breast changes, breast lump, nipple discharge
Date of last clinical breast exam: ____________
Explain: ______________________________
____

GASTROINTESTINAL
Nausea, vomiting, diarrhea, constipation, abdominal pain, blood in stool, heartburn
Explain: ______________________________
____

URINARY
Feeling of incomplete emptying, pain with urination, urgent urination, frequent urination, blood in urine
Explain: ______________________________
____

FEMALE GENITAL
Menstrual period absence, irregular periods, painful menstruation, vaginal discharge, painful intercourse, sores
Date of last menstrual period: ____________________
Date of last annual GYN exam: ____________________
Explain: ______________________________
____

MALE GENITAL
Discharge, sores, erectile dysfunction
Explain: ______________________________
____

MUSCULOSKELETAL
Back pain, joint pain or swelling, muscle weakness, stiffness, recent injury
Explain: ______________________________
____

SKIN
Rash, hives, redness, itch, suspicious lesions
Explain: ______________________________
____

NEUROLOGICAL
Numbness, tingling, seizures, fainting, tremors, paralysis, history of head injury
Explain: ______________________________
____

MENTAL HEALTH
Depression, anxiety, suicidal thoughts, thoughts of hurting others, paranoia, hearing voices
Explain: ______________________________
____

ENDOCRINE
Cold flashes, hot flashes, excessive thirst, weight loss, weight gain
Explain: ______________________________
____

BLOOD
Abnormal bruising, abnormal bleeding, enlarged lymph nodes
Explain: ______________________________
____

ALLERGIES & IMMUNITIES
Hay fever, HIV/STI exposure (occupational)
Explain: ______________________________
____

HOW WOULD YOU DESCRIBE YOUR HEALTH IN GENERAL? ____________________
____
____