**Kent State University Health Services**

**Faculty/Staff**

 **Confidential Medical History Form**

**PLEASE PRINT**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Name: Last First MI SSN# Date of Birth**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Address: Number Street Phone Cell Phone**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **City State Zip Code Emergency Contact Phone**

**Primary Person to Notify in Case of an Emergency**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Business Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ALLERGIES: ⬜ NONE Medications/Serums/other substances: Please List**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 🞏 Anxiety | 🞏 Diabetes | 🞏 Hepatitis/Liver Problems | 🞏 Thyroid Disorder | 🞏 Arthritis  |
| 🞏 Asthma/Lung Disease  | 🞏 Eating Disorder | 🞏 Cholesterol Disorder | 🞏 Anemia | 🞏 ABN/PAPS/COLP/LEEP |
| 🞏 Blood Disorder/Clots | 🞏 Seasonal Allergies  | 🞏 Low/High Blood Pressure | 🞏 Abuse |  |
| 🞏 Breast Disorder | 🞏 Stomach/Digestive Disorder |  🞏 Kidney Disorder | 🞏 Psychological Disorder  |  |
| 🞏 Cancer (specify type) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 🞏 Gynecological Disorder | 🞏 Mono | 🞏 Seizures  |  |
| 🞏 Head Injury | 🞏 Migraines | 🞏 Musculoskeletal/Back  | 🞏 Childbirth/Abortion  |  |
| 🞏 Depression | 🞏 Heart Disease/  Heart Murmur | 🞏 Skin Disorder | 🞏 Vision/Hearing Problems | Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

 **Your Medical History: ⬜ NONE Check Mark all that apply and \*explain below**

\*Additional Information\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Disability **(Specify Type): ⬜** None**\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any surgeries and hospitalizations/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **⬜**None

**PLEASE TURN OVER AND COMPLETE BACK OF FORM**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_**

**MEDICATIONS ⬜ NONE** (List all medications currently being taken with dosage, frequency and condition for which it is being taken)

|  |  |  |  |
| --- | --- | --- | --- |
| **Medications** | **Dosage** | **Frequency** | **Diagnosis** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Social History**

Alcohol Use: Amount/Frequency \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Never □ Quit

Tobacco Use: Currently smoke \_\_\_\_\_\_\_\_\_\_\_\_Cigarettes/day □Never □ Quit

Drug Use: Type/Frequency \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Never □ Quit

 **Family Medical History ⬜ NONE**

□Adopted: \_\_\_\_\_NO HX KNOWN OR \_\_\_\_\_HX KNOWN (PLEASE FILL IN BELOW)

 If any of your immediate family had/have the following check the box indicating which family member it applies to:

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Father | Mother | Sibling | Grandparent |  | Father | Mother | Sibling | Grandparent |
| Alcohol/Drug Addiction |  |  |  |  | High Blood Pressure |  |  |  |  |
| Blood Clots |  |  |  |  | Psychological Illness |  |  |  |  |
| Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |  | Kidney Disease |  |  |  |  |
| Diabetes |  |  |  |  | Stroke |  |  |  |  |
| Heart Disease |  |  |  |  | Thyroid Disorder |  |  |  |  |
| Elevated Cholesterol |  |  |  |  |  |  |  |  |  |

**Medical Restrictions/Advance Directive**

Do you have any medical restrictions associated with religious practices? □YES □NO

If yes explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a living will (advance directive)? □YES □NO

Would you like information about advance directives? □YES □NO

**Today’s Date** \_\_\_\_\_\_\_ **Patient Signature**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Reviewed Date**\_\_\_\_\_\_ Patient Init\_\_\_\_\_\_ **Reviewed Date**\_\_\_\_\_\_ Patient Init\_\_\_\_\_\_

**Reviewed Date**\_\_\_\_\_\_ Patient Init\_\_\_\_\_\_

Revised jav 5/13