Pace University Health Care

Health History and Physical

Name: _____ Academic Major: _____

Birth Date: _____ Age: _____ Date: _____ Reviewer: _____

Previous Jobs: _____

Family History

Please check (√) if you or a family member has or had any of these conditions:

Past History/ Family History: Include grandparents, aunts, and uncles.
Indicate approximate year of onset of illness.
Is it controlled? Did the person die of it (↓)?
P = Paternal, M = Maternal, example: *Paternal Grandmother = PGM*

	Self	Father	Mother	Siblings	Children	Other
Diabetes						
High Blood Pressure						
Heart Disease						
Stroke						
Cancer						
Glaucoma or Blindness						
Tuberculosis						
Alcoholism or Problem Drinker						
Nervous Breakdown or Suicide						
Hepatitis						
Urinary Infection or Kidney Disease						
Pneumonia or Lung Disease						
Rheumatic Fever or Heart Murmur						
Seizures or Epilepsy						
Asthma or Hay Fever						

Any Other Family Medical Problems not listed? _____
Fill in the current ages for biological relatives. If deceased, list age of and cause of death.

Mother: _____ Father: _____
MGM: _____ MGF: _____
PGM: _____ PGF: _____
Siblings: _____

Hospitalization, Surgery, or Major Injuries:

Approximate Date	Problem	Where Treated (Hospital and City)

Are there any other medical problems you have seen a doctor or health care practitioner about? If so, please list them:

_____
_____

Circle illness (IL) or immunization completed (IM), and give dates:

DIPTHERIA/ TETANUS- IM _____ (Most Recent)

POLIO- IL IM _____

VARICELLA (Chicken pox)- IL IM _____

Other: _____

Date of most recent TB test: _____
Have you ever had a positive reaction to a tuberculosis skin test? Y N Date: _____
Have you ever had a cholesterol test? Y N If yes, result: _____ Date: _____
Have you ever had a sickle cell test? Y N If yes, result: _____ Date: _____

Health History

Are you allergic to penicillin or to other medicines or substances (pollens, grasses, molds, dust, foods, etc.) Y N

If so, which? _____

If so, what kind of reaction do you get? _____

_____

Please list any medications you commonly use: (including birth control, aspirin, laxatives, diet pills, vitamins, herbals, etc.)

_____

Do you use recreational drugs?

Marijuana- Y N
Cocaine- Y N
Pills- Y N Type: _____

Have you ever used IV drugs? Y N Type: _____
Have you ever used steroids? Y N Type: _____

Family Planning & Sexual History

# of pregnancies _____ Outcome: _____ Dates: _____
Have you ever had sex? Y N
Are you currently sexually active? Y N
How many sexual partners have you had? _____
Do you have sex with men? _____ women? _____ both? _____
Do you have any questions about your sexual functioning, contraception, or sexually transmitted disease? Y N
Do you desire pregnancy at this time? Y N
Do you consider yourself unable to conceive/ impregnate? Y N
If using contraception, which method(s) are you using? (Circle one or more, put an X before any method you have ever used).

_____ Pill _____ IUD (loop) _____ Tied Tubes _____ Diaphragm _____ Condom (Rubber)

_____ Foam _____ Rhythm_____ Vasectomy _____ None Other: _____

Do you drink alcoholic beverages?

Beer Y N
Wine Y N
Liquor Y N

On average, how much do you drink?
(Times per week, month, or year-average) _____

Do you currently smoke? Y N
Did you ever smoke cigarettes? Y N
If so, _____ packs per day for _____ years.
If you did but no longer smoke, how long ago did you stop? _____
Do you chew tobacco? Y N

Diet History

Present Weight _____ Desired Weight _____ Highest Weight _____ Lowest Weight _____

Approximately how many times per week do you eat the following foods:

Red meat (beef, pork, lamb) _____
Chicken, turkey, fish _____
Nuts, beans, nut butter _____
Dairy products (milk, cheese, yogurt) _____
Eggs (how many per week?) _____
Fruit _____
Vegetables (cooked) _____
Vegetables (raw) _____

Whole grains (whole wheat bread, bran cereal, brown rice, oatmeal, etc.) _____
Refined grain foods (white bread, white noodles, spaghetti) _____
Cookies, cake, candy, ice cream _____
Cheese doodles, potato chips, french fries, pretzels, etc. _____

Do you drink coffee? Y N circle one:
How many cups per day? _____ caffeinated or decaffeinated?
How many cups of tea do you drink per day? _____ herbal or caffeinated?
How many sodas do you drink per day? _____ regular, diet, or caffeine Free?
Do you eat chocolate more than once a day? Y N
Have you ever tried to diet? Y N If so, what methods have you tried? _____
Have you ever made yourself vomit or taken laxatives to lose weight? Y N
Have you ever had an eating disorder? Y N

Toxic Exposure

Have you, to your knowledge, been exposed to any toxic substances such as asbestos, DES (taken by your mother during pregnancy), radiation, toxic chemical, chemotherapy? Y N If so, explain _____

_____

Safety

Do you use a seatbelt when driving? Y N When a passenger? Y N
If you have an allergy or a chronic disease do you wear an identification tag? Y N

Family Roles

How would you describe your family? What do you do together? Do they provide emotional/ financial support? Any family problems?

Current Life Situation

Where do you live, with whom? Do you have friends close by? Recent changes in living situation? Full or part time employment? Satisfied with school/ job?

Stress

Are you under a lot of stress? Y N
Do you feel that you are coping well with your stresses? Y N
How do you deal with stress? _____

Exercise

Do you follow a regular exercise program? Y N
If yes, describe (activities, times per week, frequency and length of each exercise session) _____

_____

If not, do you exercise at all? Y N
If yes, describe _____

Review of Systems

Circle N for no, Y for yes, and fill in the blanks. Feel free to comment in the space at the right. If you do not understand a question, leave it blank.

Constitutional

1.	Do you have any trouble with your appetite?	1.	Y	N
2.	Have you had more than a 10 pound change in weight in the last year?	2.	Y	N
3.	Do you have fevers or sweats?	3.	Y	N
4.	Do you notice weakness, fatigue, malaise?	4.	Y	N
5.	Are you overly sensitive to temperature changes?	5.	Y	N
6	a. Do you bruise or bleed easily?	6a.	Y	N
	b. If so, is this new?	b.	Y	N

Skin/ Hair

7.	Do you have any skin rashes or sores or itching?	7.	Y	N
8.	Do you have any moles or beauty marks that are changing or are troubling you?	8.	Y	N
9.	Are there changes in your nails?	9.	Y	N
10.	Is your skin unusually dry? Oily?	10.	Y	N
11.	Is your hair unusually dry, oily, falling out?	11.	Y	N

Eyes, Ears, Nose and Throat

12a.	Do you have eye problems or trouble with your vision?	12a.	Y	N
b.	Do you wear glasses or contact lenses? If so which? _____	b.	Y	N
13.	Do you see lights or dark spots in your field of vision?	13.	Y	N
14.	Do you have any problems with your ears or with your hearing?	14.	Y	N
15.	Do you have any sinus trouble or problems with your nose?	15.	Y	N
16a.	Do you have any problems with your teeth or gums?	16a.	Y	N
b.	Do you have dentures?	b.	Y	N
17.	Do you have any mouth sores, persistent voice changes or hoarseness?	17.	Y	N
18.	Do you use dental floss?	18.	Y	N
19.	Date of last vision exam? _____			
20.	Date of last dental exam? _____			

Neck

21.	Any pain, swelling, or limited motion of your neck?	21.	Y	N

Respiratory

22.	Do you have a persistent cough or phlegm production?	22.	Y	N
23.	Do you ever have any wheezing or other difficulty breathing?	23.	Y	N
24.	Do you ever cough up blood?	24.	Y	N

Breasts

25.	Do you have a lump, dimple, skin change, or secretion from your breasts?	25.	Y	N
26.	Do you have pain in your breasts?	26.	Y	N
27.	Do you know how to examine your breast?	27.	Y	N
28.	How often do you examine your breasts?	28.	_____	

Cardiac

29.	Do you have trouble with your breathing?	29.	Y	N
30.	Do you ever have pain or tightness in your chest?	30.	Y	N
31.	Do your ankles swell?	31.	Y	N
32.	Do you have varicose veins?	32.	Y	N
33.	Have you ever been told that you have a heart murmur?	33.	Y	N

Gastrointestinal

34.	Has your appetitive changed recently?	34.	Y	N
35.	Do you have difficulty swallowing?	35.	Y	N
36.	Do you have any stomach pains, heartburn, or vomiting?	36.	Y	N
37.	Do you have constipation or use a laxative often?	37.	Y	N
38.	Do you have frequent diarrhea?	38.	Y	N
39.	Have you passed any tarry, black or bloody bowel movements?	39.	Y	N
40.	Has there been any change in color, size or consistency of your bowel movements lately?	40.	Y	N
41.	Do you have rectal hemorrhoids?	41.	Y	N

Lymph

42.	Do you notice any lumps in your neck, armpits or groin?	42.	Y	N

Urinary

43a.	Do you get up more than once at night to urinate?	43a.	Y	N
b.	Is this new?	b.	Y	N
44.	Do you have any burning sensation with urination?	44.	Y	N
45.	Have you passed any red or dark urine?	45.	Y	N
46.	Do you have trouble starting or stopping your urine?	46.	Y	N
47.	Do you ever lose your urine accidentally when you cough?	47.	Y	N
48.	Is urination urgent? (difficult to hold in)	48.	Y	N
49a.	How many times a day do you urinate?	49a.	_____	
b.	Large, small or moderate amounts?	b.	L S M	

Genital- Female Only

50.	Age of onset of menses (periods) _____ Were menses initially regular?	50.	Y	N
51.	How often do your periods come? (cycle is every _____ days for _____ days)			
52.	Date of first day of last period?	52.	_____	
53.	Do you have any change in your monthly cycle?	53.	Y	N
54.	Do you have excessive menstrual bleeding or a period longer than 6 days? (# of pads per day/ X _____ days)	54.	Y	N
55.	Do you have strong menstrual cramps?	55.	Y	N
56.	Do you have premenstrual symptoms? If so, circle those you have: acne, breast tenderness and swelling, bloating, headaches, food cravings, mood changes, other _____ ?	56.	Y	N
57.	Do you have vaginal bleeding between your periods?	57.	Y	N
58a.	Are you bothered by a vaginal discharge or vaginal itching sores or lumps?	58a.	Y	N
b.	In the past?	b.	Y	N
59.	Do you have any pain or bleeding with intercourse?	59.	Y	N
60.	Date of last pap smear _____. Result?	60.	_____	
61.	Are you bothered by hot flashes?	61.	Y	N

Genital- Male Only

62.	Do you have any discharge or drip from your penis?	62.	Y	N
63a.	Do you have a sore or lump on or near your penis?	63a.	Y	N
b.	In the past?	b.	Y	N
64.	Do you know how to examine your testicles?	64.	Y	N
	If so, how often do you do it? _____			

Musculoskeletal

65.	Are you bothered by pains or cramps in your back, arms, legs, or joints?	65.	Y	N
66.	Do you have any numbness, tingling, weakness or swelling in your arms or legs?	66.	Y	N
67.	Do you have difficulty moving any joint?	67.	Y	N
68.	Have you ever had any bone fracture or major injury to a joint, tendon or ligament?	68.	Y	N
69.	Do you have any artificial limbs, joints, or other prosthetic devices?	69.	Y	N
70.	Have you ever been disqualified from athletic competition for any reason?	70.	Y	N
	If so, why? _____			

Neurologic - Hematologic

71.	Are you bothered by frequent headaches?	71.	Y	N
72a.	Do you have fainting or dizzy spells?	72a.	Y	N
b.	If so, has this ever occurred during exercise?	b.	Y	N
73.	Have you ever had convulsions or fits?	73.	Y	N
74.	Have you ever felt disorientated?	74.	Y	N
75.	Do you have trouble walking steadily?	75.	Y	N
76.	Have you ever lost consciousness?	76.	Y	N

Emotional

77.	Do you often feel depressed or sad?	77.	Y	N
78.	Are you upset or nervous more than you feel you should be?	78.	Y	N
79.	Do you have trouble sleeping?	79.	Y	N
80.	Have you ever had any serious trouble with your memory?	80.	Y	N
81.	Do you have difficulty interacting with friends, persons in authority, others?	81.	Y	N
82.	Do you ever feel you can't cope with your responsibilities?	82.	Y	N
83.	Do you have strong fears which influence your behavior?	83.	Y	N
84a.	Have you ever considered suicide?	84a.	Y	N
b.	If so, are you considering it now?	b.	Y	N