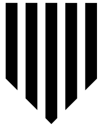

1912 SAINT JOSEPH'S COLLEGE

# HEALTH AND WELLNESS CENTER

278 Whites Bridge Road, Standish, ME 04084-5236
Tel 207-893-6634 • Fax 207-893-7865 • healthcenter@sjcme.edu

PLEASE PRINT

## PATIENT HISTORY

LAST NAME FIRST NAME MIDDLE INITIAL

DATE OF BIRTH STUDENT ID # SEX MALE [ ] FEMALE [ ]

## FAMILY MEDICAL HISTORY

| | Age | Current Health | Cause of Death (if applicable) |
|---|---|---|---|
| Father | ______ | ______________________________ | ______________________________ |
| Mother | ______ | ______________________________ | ______________________________ |
| Sibling | ______ | ______________________________ | ______________________________ |
| Sibling | ______ | ______________________________ | ______________________________ |
| Sibling | ______ | ______________________________ | ______________________________ |

| Any family history of: | Yes | No |
|---|---|---|
| Diabetes | _____ | _____ |
| Heart Disease | _____ | _____ |
| Cancer | _____ | _____ |
| Drug Abuse | _____ | _____ |

If yes, please explain _______________

## PERSONAL MEDICAL HISTORY

| | Y | N | | Y | N |
|---|---|---|---|---|---|
| Eating Disorder | | | Rubella | | |
| Alcohol/Drug Abuse | | | Hepatitis B Disease | | |
| Anxiety/Depression/Mental Illness/ADHD | | | High Blood Pressure | | |
| Asthma | | | HIV/AIDS | | |
| Cancer | | | Measles | | |
| Cardiac Condition/Heart Murmur | | | Mononucleosis | | |
| Chicken Pox | | | Mumps | | |
| Convulsions/Seizure Disorder | | | Rheumatic Fever | | |
| Dental Problems | | | Sickle Cell Anemia | | |
| Diabetes | | | Thyroid Disorder | | |
| Kidney Problems | | | Tuberculosis | | |
| Gastrointestinal Problems | | | Other | | |
| Head injury with loss of consciousness | | | | | |

| ALLERGIES | | Y | N |
|---|---|---|---|
| Food (List Food) | Life Threatening? | | |
| Drug (List Drug) | Life Threatening? | | |
| Insect (List Insect) | Life Threatening? | | |
| Other (List) | Life Threatening? | | |

PRIOR HOSPITALIZATIONS/SURGERY DATE

Previous Surgery/Hospitalization/Injury? Explain

Physical Impairment? Explain

Emotional Problems Requiring Treatment? Explain

Current Medications? List

HEALTH BEHAVIORS

Do you smoke? Y N How much?_____ Number of years?______

Do you drink alcohol? Y N How much?_____ How often?______

Do you drink caffeine? Y N How much?______________________

Do you engage in recreational drug use? Y N

Do you engage in IV drug use? Y N

Regular exercise? Y N

Use seat belts? Y N

Use bike helmets? Y N

Take vitamins/supplements? Y N