

Name: _____ KU ID#: _____ Date of Birth: _____

MEDICATION HISTORY No Current Medications

Include all prescriptions, birth control, over-the-counter meds, vitamins, supplements, and herbal preparations that you take.

Name of Medication, including dosage and frequency (example: 250 mg, one tab, twice daily)

FOOD / MEDICATION / MATERIAL ALLERGIES (Include all substances: penicillin, latex, peanuts, etc.)

No Known Food/Medication/Material Allergies

Name of Food/Medication/Material	Type of Reaction	Approx. Date of Onset

PERSONAL MEDICAL HISTORY No Significant Personal Medical History. Please select all that apply:

- | | | |
|---|--|--|
| <input type="checkbox"/> Acid Reflux/GERD | <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Sexually Transmitted Infection |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Sickle Cell Trait |
| <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Substance/Alcohol Use: |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Alcohol Drinks/week: |
| <input type="checkbox"/> Attention Deficit (ADD/ADHD) | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Smoking: () Former () Current |
| <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Tobacco Use/Other: _____ |
| <input type="checkbox"/> Cancer/Type: _____ | <input type="checkbox"/> HIV Infection | <input type="checkbox"/> Recreational Drug Use |
| <input type="checkbox"/> Concussion | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Suicidal Thoughts/Attempt(s) |
| <input type="checkbox"/> Clotting Disorder | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Thalassemia |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Urinary/Kidney Problems |
| <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Other: _____ | |
| <input type="checkbox"/> Hay Fever/Allergies | | |

Parents & Siblings Medical History

- No Significant Family History
- Alcohol/Substance Abuse
 - Cancer: _____
 - Clotting Disorder
 - Depression
 - Diabetes
 - Heart Disease
 - High Blood Pressure
 - High Cholesterol
 - Thyroid Disorder
 - Other: _____

What do you use for STI (sexually transmitted infection) protection? _____

HOSPITALIZATION / SURGICAL HISTORY (include dates) No Past Hospitalizations/Operations

Condition(s): _____

TO BE COMPLETED BY FEMALE PATIENTS ONLY: GYNECOLOGY HISTORY

- Yes No Do you skip periods?
- Yes No Have you had irregular bleeding?
- Yes No Have you had Recurrent vaginal infections?
- Contraception: Check method used in the past and currently**
 - past now Oral contraceptives — If used, what type of pill? _____
 - past now Depo Provera past now Condoms past now Spermicide
 - past now Birth Control Implant (Nexplanon/Implanon) past now IUD — Brand: _____
 - Other (specify): _____
 - How long was each method used? _____
 - Were there any problems? _____
- Date of last pelvic exam: _____
- Date of last Pap smear: _____ Was it normal? Yes No
- Date of last menstrual period: _____
- Number of pregnancies: _____ Number of live births: _____
- Have you had GYN surgery? Yes No If yes, give date and describe: _____

Patient Signature: _____ Date: _____

***** DO NOT WRITE BELOW THIS LINE – FOR INTERNAL USE ONLY*****