



INDIANA UNIVERSITY PURDUE UNIVERSITY IN MANASSAS

IUPUI HEALTH SERVICES
PATIENT REPORT OF MEDICAL HISTORY

PRINT LEGIBLE:

Last Name: First Name: MI: DOB:

FAMILY HISTORY:

Father Living \_\_\_ Dead \_\_\_ Mother Living \_\_\_ Dead \_\_\_
Age of Death \_\_\_ Cause \_\_\_ Occupation \_\_\_

Sisters 1 2 3 4 More Brothers 1 2 3 4 More

Have any of your blood relatives ever had... PLEASE CIRCLE

TUBERCULOSIS ARTHRITIS DIABETES STOMACH TROUBLE SEIZURES/CONVULSIONS
KIDNEY DISEASE ASTHMA/HAY FEVER HEART DISEASE HIGH BLOOD PRESSURE

PATIENT HISTORY

Please circle if you have ever had any of the following:

SCARLETT FEVER MEASLES (RED) GERMAN MEASLES MUMPS
CHICKEN POX POLIOMYELITIS MALARIA TUBERCULOSIS
ANEMIA SINUSITIS EYE TROUBLE GUM/TOOTH TROUBLE
EAR TROUBLE RECURRENT COLDS ASTHMA/HAY FEVER NOSE/THROAT TROUBLE
EPILEPSEY GOITRE RECURRENT HEADACHES SHORTNESS OF BREATH
CHRONIC COUGH RHEUMATIC FEVER HEART PALPITATIONS CHEST PAIN/PRESSURE
HEART MUMUR JOINT DISEASE/INJURY SHOULDER DISLOCATION TRICK KNEE
BACK PROBLEMS TUMOR/CANCER/CYST JAUNDICE GALLBLADDER TROUBLE
DIGESTIVE TROUBLE RECURRENT DIARRHEA RUPTURE HERNIA RECENT WEIGHT LOSS
DIZZINESS/FAINTING WEARINESS PARALYSIS DIABETES VENERAL DISEASE
SUGAR IN URINE IRREGULAR PERIODS EXCESSIVE MENSTRAUL FLOW SEVERE CRAMPS

Has your physical activity been restricted during the past five years? If yes, please give reasons and duration

Have you received treatment or counseling for a nervous condition, personality disorder, or emotional problems?

Have you had any surgeries? Please list

List all medications you are currently taking:

SIGNATURE DATE