myLife
preventive imaging

New Patient Health History

Name: _____

University ID: _____

Date of Birth: _____/_____/_____ **Sex:** M: □ F: □

Marital Status: Single: □ Married: □ Divorced: □

Long-term illness or condition, or any problem requiring regular treatment/care? (stomach, heart, headaches, weight, mental health/depression, blood pressure, asthma, etc.) None: □

If yes, please list: _____

_____

_____

Allergies to Medications: None: □

If yes, please list (with reaction): _____

_____

Other Allergies: Seasonal: □ Other: □ None: □

If specific, please list (if known): _____

_____

Current Medications *(name, dose)*: None: □

Prescription (Includes Birth Control): _____

_____

_____

Over the counter / herbal: _____

_____

Past history of serious illness or trauma *(broken bones, concussions, pneumonia, etc.)*: None: □

If yes, please list: _____

_____

Has anyone in your family had: cancer, heart disease, high blood pressure, diabetes, thyroid problems, mental illness, or <u>other</u> inherited conditions? None: □

If yes, please list relative & condition: _____

_____

_____

_____

Tobacco Use: Never: □ Past: □ Current: □

Type: Cigarettes/Cigar/Pipe: □ Smokeless: □

Quit when?: _____

How many?: _____ *Per:* _____

How long?: _____

Alcohol Use:

How many drinks do you average in a day? _____ *A week?* _____

How often do you binge drink (more than 4-5 drinks in one night?

_____

Street/Recreational/Illicit Drug Use: No: □ Yes: □

IV Drug Use: No: □ Yes: □

What kind?: _____

How much?: _____

How long?: _____

Screening for depression: *Over the past 2 weeks, how often have you been bothered by any of the following items?*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	*0*	*1*	*2*	*3*
2. Feeling down, depressed, or hopeless	*0*	*1*	*2*	*3*

Past Surgeries and/or hospitalizations (please list with date):

_____

_____

Females only: *# of pregnancies:* _____ *# of live births:* _____

Menses regular? No: □ Yes: □

First day of last menstrual period? _____/_____/_____

Signature: _____

Date: _____/_____/_____