



**PERSONAL MEDICAL HISTORY (ANSWER THE FOLLOWING QUESTIONS REGARDING YOU PRESENT OR PAST MEDICAL HISTORY)**

Do you have any allergies to medications?  YES  NO If yes, which?

Do you have any other allergies?  YES  NO If yes, which?

**Current Medications: List all you take, including Over-The-Counter Medications and Vitamins:**

Name of Medication	Dose	How Often Taken - daily twice daily, as needed, etc.

**Surgeries/Hospitalizations** - List all surgeries and dates (include any outpatient surgery): If more space is needed, use back or add a sheet.

		ADDITIONAL COMMENTS
1. Seizure disorder? <input type="checkbox"/> YES <input type="checkbox"/> NO Date of Last Seizure: _____ Head injury? <input type="checkbox"/> YES <input type="checkbox"/> NO Loss of Consciousness - Date _____ How Long _____		
2. Headaches? <input type="checkbox"/> YES <input type="checkbox"/> NO Migraines? <input type="checkbox"/> YES <input type="checkbox"/> NO Date Diagnosed _____ Date of Last Migraine _____		
3. Vision: Do you wear <input type="checkbox"/> glasses? <input type="checkbox"/> contacts? <input type="checkbox"/> YES <input type="checkbox"/> NO Do you have unequal pupils? <input type="checkbox"/> YES <input type="checkbox"/> NO Do you have blindness in one or both eyes? <input type="checkbox"/> YES <input type="checkbox"/> NO Do you have Glaucoma? <input type="checkbox"/> YES <input type="checkbox"/> NO Do you have Cataracts? <input type="checkbox"/> YES <input type="checkbox"/> NO Do you have Double Vision? <input type="checkbox"/> YES <input type="checkbox"/> NO Do you have other vision problems? <input type="checkbox"/> YES <input type="checkbox"/> NO Describe: _____		
4. Dizziness/Fainting <input type="checkbox"/> YES <input type="checkbox"/> NO Reason: _____ Date of occurrence: _____		
5. Do you have ear, nose or throat problems? <input type="checkbox"/> YES <input type="checkbox"/> NO Describe: _____ Hearing impairment? <input type="checkbox"/> YES <input type="checkbox"/> NO Hayfever? <input type="checkbox"/> YES <input type="checkbox"/> NO Are you currently taking shots? <input type="checkbox"/> YES <input type="checkbox"/> NO		

**PERSONAL MEDICAL HISTORY (continued)**

ANSWER THE FOLLOWING QUESTIONS REGARDING YOUR PRESENT OR PAST MEDICAL HISTORY	ADDITIONAL COMMENTS
<p>6. Do you have Pulmonary Disease? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>    Chronic Obstructive Pulmonary Disease (COPD) <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>    Pulmonary Embolism/Blood Clots? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>    Sleep Apnea? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>    Asthma? Date of last attack _____ <input type="checkbox"/> YES <input type="checkbox"/> NO                  Number of attacks in past year _____</p> <p>    Emphysema or chronic Bronchitis or Bronciectasis? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>    Shortness of Breath or Difficult Breathing? <input type="checkbox"/> YES <input type="checkbox"/> NO                  Explain: _____</p> <p>    Tuberculosis? <input type="checkbox"/> YES <input type="checkbox"/> NO                  History of positive TB skin test <input type="checkbox"/> YES <input type="checkbox"/> NO                  Have you ever received BCG? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>    Have you ever experienced altitude sickness? <input type="checkbox"/> YES <input type="checkbox"/> NO                  At what altitude _____                  Describe treatment: _____</p>	
<p>7. Do you have Heart Problems/Disease? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>    Previous Heart Attack? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>    Angina/Chest Pains? <input type="checkbox"/> YES <input type="checkbox"/> NO                  Describe (include frequency, precipitating factors, and treatments): _____</p> <p>    Congestive Heart Failure (CHF)? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>    Supraventricular Tachycardia (SVT)? Date diagnosed _____ <input type="checkbox"/> YES <input type="checkbox"/> NO                  Frequency and treatment: _____</p> <p>    Atrial Fibrillation? <input type="checkbox"/> YES <input type="checkbox"/> NO                  Date diagnosed _____</p> <p>    Heart Murmur/Valvular Heart Disease? <input type="checkbox"/> YES <input type="checkbox"/> NO                  Date diagnosed _____                  Limitations: _____</p> <p>    <input type="checkbox"/> Angiogram <input type="checkbox"/> Angioplasty <input type="checkbox"/> Stent <input type="checkbox"/> YES <input type="checkbox"/> NO              <input type="checkbox"/> Cardiac Bypass Surgery Date _____</p> <p>    Pacemaker? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>    Hypertension? Date Diagnosed _____ <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>    TIA/Stroke? Date _____ <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>    History of Deep Vain Thrombosis (DVT)/Blood Clots? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>    History of Abdominal or Cerebral Aneurysm? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	
<p>8. Do you have diabetes? Date diagnosed _____ <input type="checkbox"/> YES <input type="checkbox"/> NO              Controlled by: <input type="checkbox"/> Insulin <input type="checkbox"/> Oral Medication <input type="checkbox"/> Diet              Last Emergency Room visit:              Date of Last HA1C _____ Results _____</p>	
<p>9. Do you have Cholesterol disorders? <input type="checkbox"/> YES <input type="checkbox"/> NO              Date diagnosed _____              Controlled by: <input type="checkbox"/> Oral Medication <input type="checkbox"/> Diet</p>	
<p>10. Arthritis? <input type="checkbox"/> YES <input type="checkbox"/> NO              Type _____              Permanent disability? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	

Name \_\_\_\_\_ SSN \_\_\_\_\_

**PERSONAL MEDICAL HISTORY (continued)**

ANSWER THE FOLLOWING QUESTIONS REGARDING YOUR PRESENT OR PAST MEDICAL HISTORY	ADDITIONAL COMMENTS
11. Do you have <b>Thyroid Disease</b> ? <input type="checkbox"/> YES <input type="checkbox"/> NO Explain, if yes - include medication _____  Surgery required? <input type="checkbox"/> YES <input type="checkbox"/> NO When? _____	
12. Have you ever used <b>tobacco/tobacco products</b> ? <input type="checkbox"/> YES <input type="checkbox"/> NO  Do you currently use tobacco/tobacco products? <input type="checkbox"/> YES <input type="checkbox"/> NO Type of use <input type="checkbox"/> cigarettes <input type="checkbox"/> cigar <input type="checkbox"/> pipe <input type="checkbox"/> chew . Packs per week? _____ Number of years of tobacco use in past? _____ If you've quit, last year of use _____	
13. Have you had an <b>Exercise Stress Test/Treadmill</b> ? <input type="checkbox"/> YES <input type="checkbox"/> NO  If yes, when? _____ Where? _____	
14. Do you have a <b>regular exercise program</b> ? <input type="checkbox"/> YES <input type="checkbox"/> NO Describe: _____	
15. Have you had <b>Stomach/Bowel Problems</b> ? <input type="checkbox"/> YES <input type="checkbox"/> NO Anemia <input type="checkbox"/> YES <input type="checkbox"/> NO Black tarry stools <input type="checkbox"/> YES <input type="checkbox"/> NO Blood in stools <input type="checkbox"/> YES <input type="checkbox"/> NO Frequent or persistent diarrhea <input type="checkbox"/> YES <input type="checkbox"/> NO Gallbladder Problems/Stones <input type="checkbox"/> YES <input type="checkbox"/> NO Heartburn <input type="checkbox"/> YES <input type="checkbox"/> NO Hemorrhoids <input type="checkbox"/> YES <input type="checkbox"/> NO Inflammatory bowel disease (Crohns/Ulcerative Colitis) <input type="checkbox"/> YES <input type="checkbox"/> NO Ulcers <input type="checkbox"/> YES <input type="checkbox"/> NO Date of last flare up _____	
16. Have you been diagnosed with <b>liver problems?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO <b>Hepatitis?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO Type <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> Other	
17. Do you have <b>Kidney problems?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO History of Kidney Stones? <input type="checkbox"/> YES <input type="checkbox"/> NO Polycystic Kidney Disease? <input type="checkbox"/> YES <input type="checkbox"/> NO Frequent Urinary Tract Infections? <input type="checkbox"/> YES <input type="checkbox"/> NO	
18. Do you have a <b>history of Hernias?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO Date _____  Location _____	
19. Have you had any <b>sexually transmitted diseases?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO When? _____ Type: <input type="checkbox"/> Herpes <input type="checkbox"/> Chlamydia <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Syphilis <input type="checkbox"/> Other (specify) _____  Treated? <input type="checkbox"/> YES <input type="checkbox"/> NO When? _____ Describe: _____	
20. <b>Cancer or leukemia?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO Type/Location: _____ Date diagnosed _____ Surgery <input type="checkbox"/> YES <input type="checkbox"/> NO Chemotherapy <input type="checkbox"/> YES <input type="checkbox"/> NO Radiation Therapy <input type="checkbox"/> YES <input type="checkbox"/> NO Other Treatment: _____	

Name \_\_\_\_\_ SSN \_\_\_\_\_

**PERSONAL MEDICAL HISTORY (continued)**

ANSWER THE FOLLOWING QUESTIONS REGARDING YOUR PRESENT OR PAST MEDICAL HISTORY	ADDITIONAL COMMENTS
21. <b>Skin rash/Disease?</b> <span style="float: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</span> Describe (include duration and treatment)	
22. <b>Broken bones?</b> <span style="float: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</span> Orthopedic Pins/Plates? <span style="float: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</span> Dislocations? <span style="float: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</span> Back injuries? <span style="float: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</span> For any "YES" answers, list date, area affected and treatment:	
23. <b>Have you ever been or are you currently treated for?</b> <span style="float: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</span>  <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Depression <input type="checkbox"/> Bipolar <input type="checkbox"/> Panic Attacks <input type="checkbox"/> Anxiety Attacks <input type="checkbox"/> Obsessive/Compulsive Disorder <input type="checkbox"/> Suicide Attempts/Thoughts <input type="checkbox"/> Eating Disorders <input type="checkbox"/> Addiction <input type="checkbox"/> Other: _____  <b>Have you ever been hospitalized for psychiatric treatment?</b> <span style="float: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</span> Describe with length and dates: <b>Medications</b> <span style="float: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</span> List:	
24. <b>For Men:</b> <span style="float: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</span> History of Prostate disease including prostatitis or prostate stones? <span style="float: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</span> When? Describe treatment:  Surgery required? <span style="float: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</span>  Date _____	
25. <b>For Women:</b> Date of last period: _____ Date of last PAP Smear: _____ Results: <input type="checkbox"/> Normal <input type="checkbox"/> Other (describe):  Are you currently taking Oral contraceptives? <span style="float: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</span> History of sever Menstrual Cramps/PMS? <span style="float: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</span> Endometriosis? <span style="float: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</span> Ovarian Cysts? <span style="float: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</span> Describe treatments:	
26. <b>Do you drink alcohol?</b> <span style="float: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</span> Quantity per day _____ Total per week _____  Have you ever felt you should decrease your drinking? <span style="float: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</span> Explain:  Have you ever received a DUI or court ordered treatment? <span style="float: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</span> Describe circumstances:  Have you ever been diagnosed as an alcoholic? <span style="float: right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</span> If now sober, length of sobriety _____	

I certify that the information contained herein is complete and accurate to the best of my knowledge. I will inform the Cal Maritime Health Center medical staff of ANY medical/health changes that occur after submitting this form. I understand that failure to provide any or all of the requested information may result in a denial of my application for assignment.

\_\_\_\_\_  
 Print Name Signature

SSN: \_\_\_\_\_ Date: \_\_\_\_\_