Drexel University College of Medicine

In the tradition of Woman's Medical College of Pennsylvania and Hahnemann Medical College

Drexel Student Health Center

Year of Graduation From Drexel:_____

Please complete this form in order to ensure proper billing of your services: **PLEASE PRINT** Date: ____/_____/_____

Patient Name:_____
Last First MI

Race:_____ Ethnicity:_____ Language: _____
Other Name/Maiden Name: _____ Date of Birth: _____
Address 1:_____ SS #:_____
Address 2:_____ Sex: (M/F):_____
City, State, Zip:_____ Email :_____
Home Phone Number:_____ Cell Phone Number:_____

Emergency Contact:
Name:_____ Relationship to Patient:_____
Address 1:_____ Home Phone:_____
Address 2:_____ Work Phone:_____
City, State, Zip:_____

Allergies to Medicines, X-Ray Dyes, or Other Substances: ☐ **Yes** ☐ **No**

If yes, please list what you are allergic to and type of reactions:_____
_____

Medications: (Prescriptions, Over-the-Counter, Vitamins, Herbs, etc.)

Drug Name	Dose	Drug Name	Dose

Pharmacy Name:_____ **Phone #**_____
Address:_____

Family History:
Has any member of your family (including parents, grandparents, and siblings) ever had the following:

Illness	Which Family Member(s)	Approx. age when diagnosed
Cancer (describe type)		
Hypertension (high blood pressure)		
Heart disease		
Diabetes		
Strokes		
Mental disease (anxiety, depression, etc.)		
Drug or alcohol addictions		
Glaucoma		
Bleeding diseases		
Osteoporosis		
Other: _____		
Other:_____		

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Prevention:

Do you wear seatbelts? ☐ No ☐ Yes
Do you wear a bike helmet? ☐ No ☐ Yes
Do you smoke? ☐ No ☐ Yes
Do you drink alcoholic beverages? ☐ No ☐ Yes
Do you drink coffee/tea? ☐ No ☐ Yes
Is there a gun in your home? ☐ No ☐ Yes
If yes, is it out of reach of children and Unloaded? ☐ No ☐ Yes
Do you use drugs? ☐ No ☐ Yes
Have you engaged in any activity which has put you at risk of getting AIDS? ☐ No ☐ Yes

Do you wish to be tested? ☐ No ☐ Yes
Have you ever worked with chemicals, paints, asbestos, or other hazardous material? ☐ No ☐ Yes
Are you in a relationship in which you have been physically hurt (e.g. slapped, kicked, punched, bruised) by your partner? ☐ No ☐ Yes
Do you feel afraid of your partner? ☐ No ☐ Yes
Do you have a "living will"? ☐ No ☐ Yes
Do you have a donor card? ☐ No ☐ Yes
Occupation:_____

Past Medical History & Review of Systems:

Please circle if you have had problems with or are presently complaining of any of the following:

1. High Blood Pressure
2. Diabetes
3. Cancer
4. Heart Disease
5. Chest pain/chest tightness
6. Shortness of breath
7. Swollen ankles
8. Palpitations
9. Light-headedness
10. Frequent urination
11. Rheumatic fever
12. Asthma
13. Bronchitis
14. Pneumonia
15. Persistent cough
16. T.B. (tuberculosis)
17. Hay fever (allergies)
18. Abdominal discomfort
19. Indigestion
20. Nausea
21. Vomiting
22. Constipation
23 Diarrhea
24. Blood in stool
25. Ulcers
26. Change in bowel habits
27. Unexplained weight loss/gain
28. Hemorrhoids
29. Gall bladder disease
30. Colitis
31. Hepatitis or jaundice
32. Thyroid disease
33. Head or neck radiation
34. Headache
35. Kidney disease
36. Kidney stones
37. Difficulty urinating
38 Arthritis
39. Low back problems
40. Skin disorders
41. Blood disorders
42. Venereal diseases
43. Anxiety
44. Depression
45. Anemia
46. Alcohol abuse
47. Drug abuse
49. Last dental visit_____
50. Last Ophthalmologist visit_____

_____
_____

Please list and supply dates of:

Immunizations	Surgeries	Other Hospitalizations
☐ Hepatitis B		
☐ Pneumovax		
☐ Flu		
☐ Tetanus		

All of your medical records in this office are confidential. No one is allowed access to your information without written consent from you. If you would like your information released to a parent or guardian, you must sign a release form giving us permission.

By signing this, I confirm that the statements completed by me today are to the best of my knowledge.

_____ _____ _____
Name Signature Date