Boston University Student Health Services

Comprehensive Adult History & Physical

Affix sticker here

Date of Visit: ____

Are you having any health problems today?

Do you have any ongoing medical problems?

☐ High blood pressure ☐ Bleeding problems ☐ Sexually transmitted infections ☐ Breast Disease
☐ Diabetes ☐ GERD ☐ Kidney disease ☐ Anemia
☐ Asthma ☐ Hepatitis ☐ Thyroid Disorder ☐ Migraines
☐ Cholesterol ☐ Seizures ☐ Mental health problems

Other/Details of Above:

Have you ever had any surgery?

Please tell us what surgery you have had and when.

Women's health history

*Date of your last period*____
Was that period "on time"? ☐ Yes ☐ No
Have you ever been pregnant? ☐ Yes ☐ No
When did your last pregnancy end?_________________________________
When was your last pap smear?____________________________________
Have you had any abnormal pap smears? ☐ Yes ☐ No
When was your last breast exam?__________________________________
Have you had any breast problems? ☐ Yes ☐ No
Other/Details of Above:

Do you take any medicines, birth control, inhalers or supplements?

Please tell us what medications you take, what dose and how often.

Are you allergic to any medicines?

Please tell us about your family medical history.

Mother ☐ Living ☐ Deceased Health status__________________________
Father ☐ Living ☐ Deceased Health status__________________________
Brothers ____ Living ____Deceased Health status__________________________
Sisters ____ Living ____Deceased Health status__________________________

Maternal GM ☐ Living ☐ Deceased Health status_____________________
Maternal GF ☐ Living ☐ Deceased Health status_____________________
Paternl GM ☐ Living ☐ Deceased Health status_____________________
Paternal GF ☐ Living ☐ Deceased Health status_____________________

Are you aware that there are any of the following conditions in your family listed above?
☐ Breast cancer ☐ High blood pressure ☐ Heart disease ☐ Cholesterol
☐ Asthma ☐ Depression/anxiety ☐ Bipolar illness ☐ *Thyroid*
☐ *Diabetes* ☐ Other cancer____________________________________
☐ Other illness____

Comprehensive Adult History and Physical-2

Affix sticker here

Lifestyle choices are important health determinants for college and graduate school aged people. The following are sensitive questions that are important in assessing your overall health. This information is confidential and between you and your health care provider.

Do your exercise for 30 minutes most days of the week?	Yes	Sometimes	No
Do you always wear a seatbelt?	Yes	Sometimes	No
Do you wear a helmet when you bike or skate?	Yes	Sometimes	No
Do you use sun-block of SPF 15 or greater?	Yes	Sometimes	No
In general, are you happy with the way things are going for you?	Yes	Sometimes	No
Do you feel that you are about the right weight for your height?	Yes	Sometimes	No
Do you ever use laxatives, over-exercise or throw up on purpose after eating?	Yes	Sometimes	No
Do you ever restrict your eating because of concerns about your weight?	Yes	Sometimes	No
Do you use tobacco?	Yes How much?___________________ For how long?_________________		No
Do you drink alcohol?	Yes How much in an average week in drinks?_________		No Why? ____________________
Have you tried or do you use recreational drugs?	Yes What?_______________________ How often?____________________		No
Are there any guns in your home?	Yes		No
Have you ever had sex (oral, anal, vaginal)?	Yes Are your partners men, women or both?__________ How many partners in the last 60 days? 0-5, 5-10, >10 How many partners in your life? 0-5, 5-10, >10		No
Have you ever had a sexually transmitted disease?	Yes What?______________		No
Do you ever wonder if you are gay, lesbian or bisexual or are you unsure of your gender?	Yes	Sometimes	No
Do you use barrier methods to protect from sexually transmitted infections? (condoms)	Yes What percent of the time?__________		No
Do you feel afraid in any of your relationships?	Yes		No
Have you ever thought of killing yourself?	Yes		No

____
____
____
____
____
____
____
____
____