UNC CAMPUS HEALTH SERVICES – INITIAL PHYSICAL FORM

Date Completed:

Name *(Last, First, MI.):*		**DOB:**
Preferred Name:	**Preferred Pronoun:**	**PID:**

Gender: ☐ Male ☐ Female ☐ Transgender- Male to Female ☐ Transgender- Female to Male ☐ Unsure ☐ Other (Please explain)

Reason for Visit:

Current Medications:

Name of Medication	Dosage	Frequency Taken

MEDICAL CONDITIONS (CURRENT & PAST)

ADD/ADHD	☐ Yes	☐No	High Cholesterol	☐ Yes	☐No
Anxiety	☐ Yes	☐No	Kidney Disease	☐ Yes	☐No
Blood Clots	☐ Yes	☐No	Liver Disease, Hepatitis or Tumor	☐ Yes	☐No
Bleeding Disorder	☐ Yes	☐No	Lupus	☐ Yes	☐No
Cancer	☐ Yes	☐No	Migraine Headache	☐ Yes	☐No
Depression	☐ Yes	☐No	Without Aura	☐ Yes	☐No
Diabetes ☐ Type I ☐ Type II			With Aura (visual changes, lights, numbness)		
Eating Disorder	☐ Yes	☐No	Seizures	☐ Yes	☐No
Anorexia	☐ Yes	☐No	Thyroid	☐ Yes	☐No
Bulimia	☐ Yes	☐No	Tuberculosis	☐ Yes	☐No
Heart Disease or Condition	☐ Yes	☐No	UTI (frequent)	☐ Yes	☐No
High Blood Pressure	☐ Yes	☐No	Stroke or Stroke-like Problems	☐ Yes	☐No

ALLERGIES

Allergies/Intolerance to medications		**Allergies to Food/Insects/Latex**	
Medication	Reaction(s)	Substance	Reaction(s)

SURGICAL HISTORY

Date	Operation	Hospital

HOSPITALIZATIONS

Date	Reason	Hospital

FAMILY HISTORY

Do you have a parent, brother or sister with a history of the following: (if so, **please list relation**)

☐ *** No known Medical problems in family***

	Relation		**Relation**		**Relation**
☐ Anxiety		☐ Heart attack before age 65 in a female		☐ Other cancer	
☐ Asthma		☐ Heart attack before age 55 in a male		☐ Stroke	
☐ Bleeding		☐ High blood pressure		☐ Thyroid Disease	
☐ Depression		☐ High cholesterol		☐ Blood Clot or other clotting disorder	
☐ Diabetes Type II		☐ Skin cancer		☐ Other	

SOCIAL HISTORY

Do you drink alcohol? ☐ No If no, skip next section

How often do you have a drink containing alcohol? ☐ Never ☐ Monthly or less ☐ 2-4 times a month ☐ 2-3 times a week ☐ 4 or more times a week

How many drinks do you typically have when drinking? ☐ 1 or 2 ☐ 3 or 4 ☐ 5 or 6 ☐ 7 to 9 ☐ 10 or more

How often do you have six or more drinks on one occasion? ☐ Never ☐ Monthly or less ☐ Monthly ☐ Weekly ☐ Daily or almost daily

Has alcohol ever affected your sexual health? ☐ Yes ☐ No

Have you ever experienced a blackout due to alcohol? ☐ Yes ☐ No

Do you use tobacco? ☐ No If no, skip next section

☐ Yes # of Years ☐ Cigarettes – #/day ☐ Chew - #/day ☐ Vaping - #/day ☐ Cigars - #/day

Year quit ☐ Have you quit more than once

Planning to quit: ☐ now ☐ considering quitting ☐ no plan to quit

Do you use recreational drugs? ☐ No (If no, skip this section) ☐ Marijuana ☐ Cocaine ☐ Stimulants ☐ Ecstasy ☐ Opiate Pain Medication (Percocet, Oxy) ☐ Heroin ☐ Hallucinogens (LSD, Mushrooms, PCP) ☐ Other :

EXERCISE

Do you exercise regularly? ☐No ☐Yes Any limiting factors? ☐No ☐Yes – Explain:

Activities:

Days per week: ☐ 1-2 ☐ 3-4 ☐ 5 ☐ 6 ☐7 Duration (minutes): ☐ <15 ☐ 15-30 ☐ 30-45 ☐ 45-60 ☐>60

Exertion: ☐ Mild ☐ Moderate ☐ Heavy

REVIEW OF SYSTEMS (CHECK CURRENT SYMPTOMS ONLY)

General:	☐ Fatigue	**Gastroenterology:**	☐ Nausea	**Neuro:**	☐ Headache
	☐ Fever		☐ Vomit		☐ Numbness
	☐ Chills		☐ Diarrhea		☐ Tingling
	☐ Weakness		☐ Constipation		☐ Spinning sensation
	☐ Weight Changes		☐ Blood in stool		☐ Seizure
	☐ Night Sweats		☐ Abdominal Pain		☐ Loss of consciousness
Heart:	☐ Chest Pain		☐ Heartburn		☐ Fainting
	☐ Irregular heartbeat		☐ Pain		☐ Memory Loss
	☐ Shortness or tightness of breath	**Breast:**	☐ Nipple discharge		☐ Tremor
	☐ Lightheaded		☐ Lump	**Psych:**	☐ Depressed/Low mood
	☐ Leg swelling		☐ Skin changes		☐ Anxiety
	☐ Fainting	**Genital:**	☐ Unusual vaginal bleeding		☐ Sleep problem
Skin:	☐ Rash		☐ Unusual vaginal discharge		☐ Suicidal thinking
	☐ Change in mole		☐ Problems with orgasm		☐ Thoughts of hurting self
	☐ Lump		☐ Painful sex or sexual problems		☐ Cutting
	☐ Dry skin		☐ Unusual bumps or sores		☐ Thoughts of harming others
	☐ Itching		☐ problem with erections		☐ Hallucinations
Endocrine:	☐ Cold tolerance		☐ problem with ejaculation		☐ Paranoia
	☐ Heat tolerance	**Blood/Lymphatic:**	☐ Excessive bleeding	**Respiratory:**	☐ Wheezing
	☐ Increased thirst		☐ Swollen lymph nodes		☐ Chest tightness
	☐ Increased urination	**Muscle:**	☐ Joint pain		☐ Difficulty breathing
Ears/Nose/Throat:	☐ Ear pain		☐ Joint swelling	**Allergy:**	☐ Runny nose
	☐ Ringing		☐ Bruising		☐ Itchy eyes
	☐ Hearing changes		☐ Muscle pain		☐ Sneezing
	☐ Congestion	**Eyes:**	☐ Decreased vision		☐ Food allergy
	☐ Trouble swallowing		☐ Double vision		☐ Insect Allergy
	☐ Hoarseness		☐ Eye pain	**Urinary:**	☐Urinating frequently
			☐ Light sensitive		☐ Urgency
					☐ Pain when urinating
					☐ Blood in urine
					☐ Leaking urine

PLEASE COMPLETE ALL THE SECTIONS THAT APPLY TO YOU

RELATIONSHIP STATUS

☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Do you feel safe with your partner?	☐ No	☐ Yes
Have you experienced unwanted sexual activity as a child or as an adult?	☐ No	☐ Yes
Within the past year have you been hit, slapped, kicked or otherwise physically hurt by someone?	☐ No	☐ Yes

SEXUAL HISTORY

Sexual Identity: ☐ Heterosexual ☐ Lesbian ☐ Gay ☐ Bisexual ☐ Queer ☐ Unsure ☐ Other

Have you engaged in sexual contact with: ☐ Men ☐ Women ☐ Both ☐ Neither ☐ N/A (skip section)

SEXUAL ACTIVITY

If yes, please mark sexual activity type: ☐ Oral sex ☐ Vaginal intercourse ☐ Anal receptive ☐ Anal penetrative

Age at first intercourse	Number of sexual partners/contact in the last year
Total lifetime partners	Are you in a mutually monogamous relationship? For how long?

How often do you use condoms/barriers/dam when having anal sex: ☐ All ☐ Most ☐ Some ☐ Never ☐ N/A

How often do you use condoms/barriers/dam when having vaginal sex: ☐ All ☐ Most ☐ Some ☐ Never ☐ N/A

How often do you use condoms/barriers/dam when having oral sex: ☐ All ☐ Most ☐ Some ☐ Never ☐ N/A

SEXUALLY TRANSMITTED INFECTION HISTORY

Have you ever been tested for Sexually Transmitted Infections (STI's)?	☐ No	☐ Yes	☐ N/A
Have you ended or started sexual contact since your last STI testing?	☐ No	☐ Yes	
Do you want STI testing today?	☐ No	☐ Yes	

Have you ever been diagnosed with or treated for any of the following:	☐ Chlamydia	☐Hepatitis B
	☐ Genital Herpes	☐ Syphilis
	☐ Oral Herpes	☐ Gonorrhea
	☐ HPV (genital warts)	☐ Other

Have you discussed Sexually Transmitted Infections (STI) risk with contacts/partners? ☐ No ☐ Yes

VACCINATIONS

HPV: ☐ Started ☐ Completed 3 shots

GYNECOLOGY

Date of last Pap: ☐ Normal ☐ Abnormal Results:

Have you ever had an abnormal pap? ☐ Yes ☐ No Dates: Results:

Have you had Colposcopy? ☐ Yes ☐ No Dates: Results: Biopsy Results:

MENSTRUAL HISTORY

Age at first period? Period comes every how many days? Period usually lasts how many days?

First day of your last period: Was it normal? ☐ Yes ☐ No Do you spot between periods? ☐ Yes ☐ No

Periods are: ☐ Light ☐ Moderate ☐ Heavy ☐ Regular ☐ Irregular ☐ Painful

Do you take medication for PMS or menstrual cramps or cycle regulation? ☐ Over the counter ☐ Prescription

Have you had unprotected sex since your last period? ☐ No ☐ Yes (Dates):

CONTRACEPTIVE HISTORY

Pregnancy prevention is not needed because?

Current pregnancy prevention method? How long used?

What pregnancy prevention method do you want to use now?

What pregnancy prevention method have you used in the past?

Note any problems with that method:

PREGNANCY HISTORY

☐ Not Applicable (skip section) ☐ Never Pregnant ☐ Currently Pregnant ☐ Currently breastfeeding

Have you ever been pregnant? ☐ Yes ☐ No ☐ Unsure

If yes, what was the outcome? ☐ birth # _____ ☐ abortion # _____ ☐ miscarriage # _____ ☐ ectopic pregnancies # ____

Complications or comments:

Thank you for taking the time to complete this form. The information will help us to better take care of you while you are here at UNC!