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 CONDITONS (CURRENT & PAST)

ADD/ADHD	☐ Yes	☐No	Heart Disease or Condition	☐ Yes	☐No
Anxiety	☐ Yes	☐No	High Blood Pressure	☐ Yes	☐No
Blood Clots	☐ Yes	☐No	High Cholesterol	☐ Yes	☐No
Bleeding Disorder	☐ Yes	☐No	Kidney Disease	☐ Yes	☐No
Cancer	☐ Yes	☐No	Liver Disease, Hepatitis or Tumor	☐ Yes	☐No
Depression	☐ Yes	☐No	Lupus	☐ Yes	☐No
Diabetes	☐ Yes	☐No	Migraine Headache	☐ Yes	☐No
Type I	☐ Yes	☐No	Without Aura	☐ Yes	☐No
Type II	☐ Yes	☐No	With Aura (visual changes, lights, numbness)	☐ Yes	☐No
Eating Disorder	☐ Yes	☐No	Seizures	☐ Yes	☐No
Anorexia	☐ Yes	☐No	Tuberculosis	☐ Yes	☐No
Bulimia	☐ Yes	☐No	UTI (frequent)	☐ Yes	☐No
Other			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****	☐ Heart attack before age 55 in a female	☐ Stroke
☐ Anxiety	☐ Heart attack before age 45 in a male	☐ Thyroid Disease
☐ Asthma	☐ High blood pressure	☐ Blood Clot or other clotting disorder
☐ Bleeding	☐ High cholesterol	☐ Other
☐ Depression	☐ Skin cancer	
☐ Diabetes Type II	☐ Other cancer	

SOCIAL HISTORY

Do you drink alcohol? ☐ No - If no, skip next section ☐ Yes - If yes, answer questions 1-5 that applied for the last 3 months

1. 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
2. How many drinks do you typically have when drinking? ☐ 1 or 2 ☐ 3 or 4 ☐ 5 or 6 ☐ 7 to 9 ☐ 10 or more
3. How often do you have six or more drinks on one occasion? ☐ Never ☐ Monthly or less ☐ Monthly ☐ Weekly ☐ Daily or almost daily
4. Has alcohol ever affected your sexual health? ☐ Yes ☐ No
5. Have you ever experienced a blackout due to alcohol? ☐ Yes ☐ No

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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

Please check the recreational drug you currently use or have used in the past: ☐ None ☐ Marijuana ☐ Cocaine ☐ Stimulants ☐ Ecstasy ☐ Opiate Pain Medication (Percocet, Oxy) ☐ Heroin ☐ Hallucinogens (LSD, Mushrooms, PCP) ☐ Other :________________________________

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

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 ALL THAT APPLY)

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

PLEASE COMPLETE ALL THE SECTIONS THAT APPLY TO YOU

SEXUAL HISTORY

Sexual Identity: ☐ Heterosexual ☐ Lesbian ☐ Gay ☐ Bisexual ☐ Queer ☐ Unsure
☐ Other (Please explain)

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

If yes, please mark sexual activity type:
☐ Oral sex on penis ☐ Oral sex on vaginal area/vulva ☐ 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? ______

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

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

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

STI History	If Yes, Please Explain if Necessary
Have you ever been tested for Sexually Transmitted Infections (STI's)?	☐ No ☐ Yes
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

Check if you received the following vaccines	
	☐ HPV Dates: #1 ______________ #2 ______________ #3______________
	☐ Hepatitis B Dates: #1 ______________ #2 ______________ #3______________

GYNECOLOGY

Date of last Pap:

Have you ever had an abnormal pap? ☐ Yes ☐ No Dates: Please Describe results:

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

MENSTRUAL HISTORY

Age at first period? __________ Period comes every ____________ days Period usually lasts ____________ 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!

Phone: 919-966-2281 Fax: 919-966-0616
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