Utah Valley University
Student Health Services

INITIAL EVALUATION

(Your responses will help the initial evaluation and will be included in your chart. Please answer questions as accurately as possible.)

Name: Date of Birth: Today's Date:

PERSONAL TREATMENT HISTORY

Medical Problems (check all that have been present/diagnosed):

Asthma	Fainting/Syncope	Kidney Problems
Arthritis	Fibromyalgia/Chronic Fatigue	Significant Head Injury
Allergies (seasonal)	Liver Problems/Jaundice	Seizures
Acid Reflux	Heart Arrhythmia	Sleep Apnea
Bleeding Disorder ______________________	Heart Attack	Stroke
Cancer ______________________________	Heart Failure	Stomach Ulcers
Dementia	High Cholesterol	Tics
Diabetes (adult onset)	High Cholesterol	
Other_____________________		
Diabetes (childhood onset)	Irritable Bowel	Other_____________________

Mental Health Problems (check all that have been present/diagnosed):

ADHD	Developmental Problem/Learning	Panic Disorder
Alcohol or Drug Problems	Eating Disorder (Anorexia or Bulimia)	Posttraumatic Stress Disorder
Bipolar Disorder	Generalized Anxiety Disorder	Psychosis/Schizophrenia/affective
Depression	Obsessive-Compulsive Disorder	Other___________________

Hospitalizations for Psychiatric Reasons/Surgeries/Accidents, Etc. (Specify year, location, type and length of admission):

1.	4.	7.
2.	5.	8.
3.	6.	9.

Sugeries/Etc./Treatments (Specify year performed and type):

1.	3.	5.
2.	4.	6.

Outpatient Treatment Programs/Psychotherapy (Specify year(s) and type):

1.	3.	5.
2.	4.	6.

Allergies to Medications: None Allergy to:______________________ Reaction(s):__________________________

Current Medications and Doses:

Past Medications (Taken for mental health issues):

Medication	When Started	When Stopped	Benefits	Side Effects

Physical Review of Systems

(Mark any which have been present to a significant degree, especially those present in the last 2-3 months)

General:

Change in Weight (up/down)
Change in Appetite (up/down)
Fever/Chills/Night Sweats
Fatigue

Head/Eyes/Ears/Nose/Throat:

□ Headaches
□ Hair Loss
□ Changes in Vision
□ Changes in Hearing
□ Ringing in Ears
□ Dizziness
□ Nose Bleeds
□ Loss of Smell
□ Trouble Swallowing
□ Change in Voice
□ Snoring During the Night

Skin:

□ Rashes
□ Itching

Cardiovascular Pulmonary:

Chest pain
Palpitations/Fast Heart Beat
Shortness of Breath
Leg Swelling
□ Trouble Breathing
□ Leg Pain when walking
□ Cough
□ Wheezing

Gastrointestinal:

□ Abdominal Pain
□ Heartburn
□ Nausea
□ Vomiting
□ Diarrhea
□ Constipation
□ Red or Black/Tarry Stools

Genitourinary:

□ Burning with Urination
□ Excessive, Frequent Urination
Painful Urge to Urinate
Excessive Waking to Urinate
Bloody Urine
Excessive Quantities of Urine

Reproductive:

□ Irregular Menstrual Periods
□ Heavy Menstrual Flow
□ Bleeding between Periods
□ Low Sex Drive
□ Difficulty Reaching Orgasm
□ Erectile Dysfunction
□ Currently Pregnant
□ Prior Miscarriage(s)

Neurological:

□ Loss of Consciousness
□ Uncontrolled Shaking/Tremor
□ Numbness (Location__________)
□ Pins and Needles Sensation
□ Burning Sensation
□ Loss of Strength
Loss of Coordination

Musculoskeletal:

Joint Pain
Stiffness
□ Limited Movement
□ Back Pain

Metabolic:

□ Constant/Excess Thirst
□ Excess Discomfort w/ Hot
□ Excess Discomfort w/ Cold
□ Dizziness w/ Standing
□ Shakiness/Dizziness w/Fasting

Hematologic:

□ Unexplained Bruising
□ Unexplained Bleeding

Other:

□ ___________________
□ ___________________
□ ___________________
□ ___________________

Family History

(Medical and Mental Health problems diagnosed in your family)

Record Letters - **F=Father, M=Mother, B=Brother, S=Sister, D=Daughter, SN=Son, GF=Grandfather, GM=Grandmother, A=Aunt, U=Uncle):**

Cancer ________________________________
Diabetes ________________________________
Fainting ________________________________
Liver Problems/Jaundice_________________
Heart Arrhythmia _______________________
Heart Attack ___________________________
Schizophrenia_________________
High Cholesterol ________________________

Stroke _______________________
Tics _________________________
Other ________________________
____
ADD/ADHD _________________
Alcohol or Drug Problems________
Anxiety/Panic/PTSD_____________

Autism _____________________
Bipolar Disorder_______________
Dementia ___________________
Depression __________________
Obsessive Compulsive Disorder_
Schizoaffective Disorder________

Kidney Problems ______________________ Asperger's ____________________ Other ___________________

Social History (your background)

Please provide brief answers. Feel free to explain further during visits with the doctor:

Where raised? ____________________________________

Number of siblings: ______ Where in birth order? _______

Relationship with father: Close Distant Conflict Good
1-2 word description of father:________________________

Relationship with mother: Close Distant Conflict Good
1-2 word description of mother:_______________________

Childhood experiences: Good childhood Frequent moves Parents divorced Parents fought frequently Teased by peers Difficulty making friends Frequently involved in physical fights Legal problems/charges
Other____
____

Early education: Learning disabilities Resource Mainstream Alternative school Home school
Other______________________________
High school graduation

Higher education:
Certificate(s) in:_________________________________
Undergraduate major:_____________________________
Other_______________ Graduate school:________________________________
____

Marital status: Single Married Div. Sep. Wid.
Number of marriages: ___________
Number of children and ages:_______________________________

Closest relationship(s): Spouse Parent Friend(s) Partner Siblings Children Others______________________________

Living situation: Alone with Roommates with Family
with Others____

Job history: 5 or less prior jobs 6-20 prior jobs greater than 20 prior jobs Fired multiple times
Why?________________________
Currently working
Current occupation/job:____
If not able to work, last time held a job:__________________________

Financial support: Self (working) Spouse Parents School loans Social security

Recent stresses:
Marriage School Work Financial Legal Health problems Other relationship Death(s)

Signature

The above information is true to the best of my knowledge.

____ Date:__________________________
Patient/Guardian signature

____ Date:__________________________
Physician signature