



Graham Health Center
Rochester, MI 48309-4401
(248) 370-2341

UNIVERSITY USE ONLY:
To be completed by hiring department or HR prior to physical

FUND CODE: _____

Department Name: _____

Supervisor or contact name: _____

Phone Number: _____

Employee Information:

Name: _____

G# _____ Date: _____

Title of Position: _____

Student Employee: ___no ___yes

Start date: _____

Immunization History:

Tetanus Vaccine: _____

Hepatitis B Vaccine (if required)

#1 _____

#2 _____

#3 _____

Flu Vaccine: _____

MMR Vaccine:

#1 _____

#2 _____

GRAHAM HEALTH CENTER – HEALTH HISTORY

ALLERGIES TO MEDICATIONS?

MEDICAL HISTORY Please check all that apply	PAST	NOW
Attention Deficit/Hyperactivity		
Alcohol/Drug Problems		
Eating Disorder		
Arthritis		
Asthma/Chronic Bronchitis		
Cancer		
Cholesterol or lipid problems		
Depression/Anxiety		
Diabetes		
Digestive Problem		
Fractures/Broken Bones		
Gallbladder/Liver disease		
Heartburn		
Hay fever or sinus problems		
Headaches (chronic or migraine)		
Head Trauma		
Heart Problems		
High Blood Pressure		
HIV Infection		
Kidney or Bladder problems		
Liver problem (hepatitis)		
Mononucleosis		
Joint & Bone Problem		
Psychiatric Problems		
Pneumonia		
Rheumatic or Scarlet fever		
Sexually Transmitted Infection		
Seizures		
Speech/Hearing/Vision Problem		
Skin problems (eczema, psoriasis)		
Stroke/Blood Clot		
Thyroid/Endocrine Problem		
Blood Clot in Veins		
Tuberculosis		
Other		

CURRENT MEDICATIONS (include vitamins, herbs, and over the counter)

Any previous surgery?

Family History		
	Current Age	Medical Problems
Father		
Mother		
Siblings		
Children		

FEMALES ONLY
When was your last menstrual period?
Are your menstrual periods regular? Yes or No
Do you have any menstrual problems? Yes or No
Number of pregnancies?
Number of live births?
Number of miscarriages?
Number of abortions?
When was your last pap smear?
When was your last mammogram?

NAME: _____ G# _____
 DATE: _____ REVIEWED BY: _____