Student Health Services
5500 Campanile Drive
San Diego, CA 92182-4701
TEL: 619-594-4325
FAX: 619-594-3638
http://shs.sdsu.edu

SAN DIEGO STATE UNIVERSITY

# HEALTH HISTORY

**CONFIDENTIAL**
**The information you provide will be used to assist in your care at Student Health Services**

LEGAL NAME: _____ RED ID: _____ BIRTHDATE: _____
Last First MI

BIRTH SEX: MALE/FEMALE/INTERSEX PREFERRED NAME/PRONOUNS: _____ GENDER IDENTITY: _____

CURRENT ADDRESS (Street/City/State/Zip): _____

PHONE #: **(**_____**)**_____ E-MAIL ADDRESS: _____ BIRTHPLACE:_____

**YES** **NO**

☐ ☐ Do you take any medications, over-the-counter products or dietary supplements? Please list:

_____

☐ ☐ Do you have any allergies/sensitivities or serious reactions to medications, bee stings, particular foods, or other materials? If yes, please list:

_____

## PERSONAL MEDICAL HISTORY

**YES** **NO** ***If yes, please circle the condition and briefly explain:***

☐ ☐ Severe head injury or concussion:
☐ ☐ Severe headaches or migraines:
☐ ☐ Brain or nerve disorders/seizures:
☐ ☐ Depression, anxiety, eating disorder or other mental health problem(s):
☐ ☐ Vision or hearing problems:
☐ ☐ Nasal or skin allergies:
☐ ☐ Thyroid disease:
☐ ☐ Asthma or lung disease/positive tuberculosis skin test:
☐ ☐ Heart disease, high cholesterol or high blood pressure:
☐ ☐ Blood clot in legs or lungs:
☐ ☐ Anemia or other blood disorder/sickle cell/G6PD deficiency:
☐ ☐ Stomach or intestinal problems:
☐ ☐ Liver or gallbladder disease/hepatitis:
☐ ☐ Kidney disease:
☐ ☐ Chronic or recurrent skin disease:
☐ ☐ Arthritis or other *current* bone/joint/muscle condition that required surgery:
☐ ☐ Cancer/leukemia/lymphoma:
☐ ☐ Diabetes: Type I ☐ or Type II ☐
☐ ☐ HIV or other cause of immune system suppression:
☐ ☐ Uterine fibroids or abnormalities/endometriosis (If applicable):
☐ ☐ Ovarian cyst or abnormalities (If applicable):
☐ ☐ Hospitalization/surgery:
☐ ☐ Other:

**Please See Reverse**

## DO YOUR ***BIOLOGICAL*** PARENTS OR SIBLINGS HAVE ANY OF THE FOLLOWING?

**YES** **NO** ***If yes, please circle the condition and indicate which biological family member:***

☐ *I do not know the medical history of my* ***biological*** *family*

☐ ☐ Mental health problem(s):
☐ ☐ Alcohol or drug abuse:
☐ ☐ Stroke or heart attack in father or brother under age 55 or mother or sister under age 65:
☐ ☐ High cholesterol:
☐ ☐ High blood pressure:
☐ ☐ Blood clot in legs or lungs:
☐ ☐ Diabetes: Type I ☐ or Type II ☐
☐ ☐ Cancer (list type):
☐ ☐ Other diseases that may run in your *biological* family:

## HABITS AND BEHAVIORS

**YES** **NO**

☐ ☐ Do you exercise? If yes, how many days per week do you engage in moderate to strenuous exercise like a brisk walk? _____
On average, how many minutes do you engage in exercise at this level? _____
☐ ☐ Do you smoke cigarettes or use other types of tobacco? If cigarettes, how many per day? _____
☐ ☐ Do you drink alcohol? If yes, how many drinks do you have per week? Please list: _____
☐ ☐ In the past month, have you had 5 or more alcoholic drinks in a day (men) or 4 or more alcoholic drinks in a day (women)? If yes, does this cause problems for you? ☐Yes ☐No
☐ ☐ Do you use marijuana? If yes, how many days per week? _____
☐ ☐ Have you used a prescription medication for non-medical reasons? If yes, what do you take?
_____
☐ ☐ Have you ever injected drugs? If so, have you ever shared needles? ☐Yes ☐No
☐ ☐ Do you use any other substances/medications not mentioned above? If yes, please list:
_____
How many times in the past year have you used an illegal drug or used a prescription for non - medical reasons (excluding alcohol or marijuana)? Please list number of times per year: _____
☐ ☐ Are you worried or has anyone ever told you that you may have a problem with drugs or alcohol?
☐ ☐ Would you like assistance in reducing tobacco, alcohol and/or drug use?
☐ ☐ Are you having any problems or concerns with personal safety, mental, physical or sexual abuse?
☐ ☐ Do you have any questions or concerns about your sexual orientation and/or gender identity?

**IN AN EMERGENCY NOTIFY**:

NAME:_____ ADDRESS:_____
Street City State Zip Code

PRIMARY PHONE: **(** **)** _____ ALTERNATE PHONE: **(** **)** _____ RELATIONSHIP: _____

## PROVIDER USE ONLY

Provider Comments:

_____ _____
(Provider Signature) (Date)