UC HASTINGS SHS PERSONAL HEALTH HISTORY QUESTIONNAIRE

In order to allow us to provide you with the best possible care, we are interested in knowing about your medical needs. Please take the time to carefully complete this personal health history which will be a part of your medical record. It is very useful for our health care team to have your updated immunization/ shot records as well as any significant medical history. Please call Student Health Services at 415- 565- 4612 if you have any questions about your special health care needs before your arrival at UC Hastings.

PERSONAL INFORMATION please print or type

Last Name First Name Middle Initial								Date of Birth	Age	Gender
Student ID #								Telephone Number:		OK to leave message: YES ☐ NO ☐
Birthplace								Email		
Emergency Contact								Relationship (parent/spouse/friend)		Emergency Contact Tel Number ( )
Emergency Contact Address Street City State Zip										

MEDICATIONS List all prescription and over the counter medications, herbs and vitamins you take on a regular basis

Name/Frequency *Name/Frequency* *Name/Frequency*

_____

_____

_____

ALLERGIES List names of medicines or foods that have resulted in an unfavorable reaction. State reaction.

Medications_____

_____

Food or others (latex, insect bites, environmental) _____

_____

IMMUNIZATIONS List dates for these immunizations or attach a copy of your immunization record

Most recent Tetanus-Tdap			
Hepatitis B (series of 3)			
MMR—measles, mumps, rubella (2 in lifetime)			
Last TB test and result			
Hepatitis A (series of 2)			
Meningitis			
Polio (OPV, IPV)			
Varicella (Chicken Pox)			
HPV (Gardasil) (Series of 3)			
Other			

PERSONAL HEALTH HISTORY QUESTIONNAIRE (page two)

MEDICAL HISTORY

Check the conditions below which you have now, or have had in the past. Indicate the year you first experienced symptoms/onset.

- ☐ abnormal pap smear
- ☐ acne (severe)
- ☐ alcohol/substance abuse
- ☐ allergies needing medication
- ☐ ADD/ADHD
- ☐ Anxiety or depression
- ☐ asthma
- ☐ bleeding disorder
- ☐ blood clot in vein
- ☐ cancer or tumor
- ☐ chicken pox
- ☐ diabetes
- ☐ eating disorders
- ☐ eczema or psoriasis
- ☐ headaches (migraine)
- ☐ heart disease
- ☐ hepatitis
- ☐ Herpes Simplex
- ☐ high blood pressure
- ☐ intestinal disorder
- ☐ mononucleosis
- ☐ pneumonia/lung problems
- ☐ pregnancy
- ☐ psychological problems
- ☐ seizures
- ☐ sexually transmitted infection
- ☐ smoker presently
- ☐ thyroid disorder
- ☐ tuberculosis or (+) test
- ☐ ulcers
- ☐ urinary tract disease
- ☐ **none of the above**
- ☐ other_____

Briefly give details of any of the conditions you have checked.

Please tell us if you have any conditions/physical restrictions or other health problems (including emotional and/or mental health) which require special arrangements.

SURGICAL, HOSPITALIZATION, TRAUMA HISTORY

Please list the type and date of any surgeries, hospitalizations, or serious injuries you have had.

FAMILY HISTORY Please indicate which if any blood relatives (i.e. parents, grandparents, siblings) have had the following diseases:

Alcohol/Drug Abuse_____
Asthma_____
Bleeding Disorder_____
Blood clot in leg or lung_____
Cancer_____
Depression_____
Diabetes_____
Eating Disorder_____
Gynecologic problems_____
Heart Disease_____
High Cholesterol_____
Hypertension_____
Intestinal Disorder_____
Kidney Disease_____
Mental Illness_____
Migraine headaches_____
Neurologic Disorder_____
Premature death_____
Stroke_____
Suicide attempt_____
Thyroid disease_____
Other_____
Unknown_____

I certify that to the best of my knowledge this information is complete and accurate.

_____ Student's Signature

_____ Date