UCSB Student Health Service
Confidential Health History

Legal Name: ________________________ Preferred Name (If Different): ___________________

Perm #:__________________   Major: _______________________

Pronouns:  □ she/her/hers  □ he/him/his  □ they/them/theirs  □ ze/hir/hirs  □ other______________

In an emergency who should we notify?  Name: ___________________ Cell #: ______________   Relationship: ____________________

Are you currently under medical treatment?  □ Yes  □ No   If yes, for what? ________________________________________________

Have you ever had an allergic reaction?  □ Yes  □ No   If yes, to what? ________________________________________________

Health History:

Have you had:

1. Serious illnesses / hospitalizations / surgeries
2. Frequent or severe headaches
3. Dizziness or fainting spells
4. Severe head injury
5. Eye problems/surgery (not contacts or glasses)
6. Hearing problems or ear surgery
7. Active tuberculosis or positive TB skin test
8. Severe chest pain / difficulty breathing
9. Chronic or recurrent diarrhea or constipation
10. Rectal bleeding or black tarry stools
11. Numerous or unusual moles / skin growths
12. Chronic or recurrent back trouble
13. Swollen, painful, unstable or disabled joints
14. Irregular or missed periods
15. Severe menstrual cramps
16. Followed a special diet
17. Tried to lose weight by fasting, diet pills, laxatives or vomiting

Personal History (you)  Biological History (Parent or Sibling)

Have you or an immediate blood relative had:  No Current Past   ✓ Comments:

1. Cancer / leukemia
2. Diabetes
3. Thyroid disease
4. Neurologic disorders / seizures
5. Allergies, sinus problems
6. Asthma
7. Heart problems / heart murmur
8. High cholesterol
9. High blood pressure
10. Blood clots or vein problems
11. Anemia / blood disorders
12. Stomach, intestinal problems or ulcer
13. Hepatitis / Liver disease
14. Kidney or Bladder problems / infections
15. Chronic or recurrent skin disease
16. ADD/Learning Disabilities
17. Anorexia / Bulimia / Eating Disorder / Obesity

Core Family Information: Are you adopted?  □ Yes  □ No   Are your parents:  □ married  □ separated  □ divorced  □ widowed

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<thead>
<tr>
<th>Relationship</th>
<th>Age(s)</th>
<th>State of health</th>
<th>Occupation</th>
<th>If deceased, cause of death</th>
<th>Age at death</th>
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<td>Parent</td>
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### Safety History:
- ☐ Yes ☐ No - Has a partner or friend ever hit, kicked, or otherwise hurt or threatened you?
- ☐ Yes ☐ No - Do you or your roommates have any weapons at your school residence? If yes, are they kept locked? ☐ Yes ☐ No
- ☐ Yes ☐ No - Have you ever experienced any unwanted sexual activity you want to discuss?
- ☐ Yes ☐ No - Do you have any concerns about violence at home or school? If yes, was alcohol involved? ☐ Yes ☐ No

**Answers to the following questions help your clinician provide appropriate care for you.**

### Social History:
- ☐ Yes ☐ No - If you drink alcohol, on average, how many drinks per occasion? _____ How many times per week? _____
- ☐ Yes ☐ No - Have you experienced a blackout or had memory blanks in the last 6 months? ____________________________
- ☐ Yes ☐ No - Do you currently use tobacco? ☐ Cigs ☐ E-Cigs ☐ Hookah ☐ Chew How much? _________ For how long? _________
- ☐ Yes ☐ No - Do you smoke marijuana? Do you use ☐ daily ☐ several days a week ☐ weekends ☐ infrequently
- ☐ Yes ☐ No - Have you used other recreational drugs besides marijuana in the past 6 months? If yes: what?
- ☐ Yes ☐ No - Have you ever used prescription medication other than what has been prescribed for you? If so what?
- ☐ Yes ☐ No - Have you had counseling through the UCSB Alcohol and Drug Program? ☐ CASE ☐ SAM ☐ Other Program
- ☐ Yes ☐ No - Have you ever received medical care or been hospitalized for alcohol or drug use disorder? ☐ Yes ☐ No
- ☐ Yes ☐ No - Are you in recovery from alcohol or drug addiction? Are you interested in support to lead a sober lifestyle? ☐ Yes ☐ No

### Mental Health History:
- ☐ Yes ☐ No - Have you ever been seen by a counselor or a psychiatrist?
- ☐ Yes ☐ No - Have you ever taken medication for mental health problems?
- ☐ Yes ☐ No - Have you ever received medical care or been hospitalized for a mental health problem or an eating disorder?
- ☐ Yes ☐ No - Have you ever thought things would be better if you were dead? If yes: when?
- ☐ Yes ☐ No - Have you had thoughts of harming or killing yourself? If yes: when?

### Pregnancy/Menstrual History (if applicable) ☐ N/A (Skip to next section)
- ☐ Yes ☐ No - Have you ever been pregnant? How many times? _________ How many live births? _________ How many terminations? _________
- ☐ Yes ☐ No - Have you had unprotected intercourse since your last period?
- ☐ Yes ☐ No - Do you have irregular or missed periods?
- ☐ Yes ☐ No - Do you have severe menstrual cramps?
- ☐ Yes ☐ No - Have you ever had an abnormal Pap?

### Sexual History: Three doses HPV vaccine recommended. I have had: ☐ unknown ☐ none ☐ one dose ☐ two doses ☐ three doses
- ☐ Yes ☐ No - Have you ever been sexually active?
- ☐ Yes ☐ No - Have you had a new sex partner in the past six months?
- ☐ Yes ☐ No - Do you consistently use condoms for STD protection for: ☐ oral ☐ vaginal ☐ receptive anal ☐ penetrative anal sex?

How many partners have you had in your lifetime? Number: __________

- Have you ever had: ☐ vaginal sex (Where you are the penetrative partner) ☐ vaginal sex (Where you are the receptive partner)
  - ☐ penetrative anal sex ☐ receptive anal sex ☐ oral sex
- Do you have sex with: ☐ Men ☐ Women ☐ Other __________________________

What method of birth control do you use? Check all that apply: ☐ None ☐ Withdrawal ☐ External ("male") Condoms
- ☐ Oral Contraceptives ☐ Plan B ☐ Nuvaring ☐ Nexplanon/Implanon ☐ IUD ☐ Depo Provera ☐ Internal ("female") Condoms
- ☐ Tubal ligation/hysterectomy ☐ Vasectomy ☐ Other __________________________