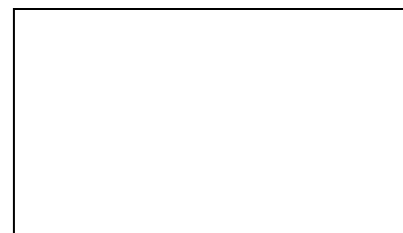


UCSB Student Health Service Confidential Health History



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:	No	Current	Past	Comments:
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. Recent change in weight, increase or decrease				
17. Followed a special diet				
18. Tried to lose weight by fasting, diet pills, laxatives or vomiting				

	Personal History (you)			Biological History (Parent or Sibling)	
	No	Current	Past	✓	Comments:
Have you or an immediate blood relative had:					
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? <input type="checkbox"/> Yes <input type="checkbox"/> No Are your parents: <input type="checkbox"/> married <input type="checkbox"/> separated <input type="checkbox"/> divorced <input type="checkbox"/> widowed					
Relationship	Age(s)	State of health	Occupation	If deceased, cause of death	Age at death
Parent					
Parent					
Sibling					
Sibling					

UCSB Student Health Service Confidential Health History

Safety History:
<input type="checkbox"/> Yes <input type="checkbox"/> No - Has a partner or friend ever hit, kicked, or otherwise hurt or threatened you?
<input type="checkbox"/> Yes <input type="checkbox"/> No - Do you or your roommates have any weapons at your school residence? If yes, are they kept locked? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No - Have you ever experienced any unwanted sexual activity you want to discuss?
<input type="checkbox"/> Yes <input type="checkbox"/> No - Do you have any concerns about violence at home or school? If yes, was alcohol involved? <input type="checkbox"/> Yes <input type="checkbox"/> No

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

Social History:
<input type="checkbox"/> Yes <input type="checkbox"/> No - If you drink alcohol, on average, how many drinks per occasion? _____ How many times per week? _____ *SBIRT (805) 451-9854
<input type="checkbox"/> Yes <input type="checkbox"/> No - Have you experienced a blackout or had memory blanks in the last 6 months? _____ *SBIRT (805) 451-9854
<input type="checkbox"/> Yes <input type="checkbox"/> No - Do you currently use tobacco? <input type="checkbox"/> Cigs <input type="checkbox"/> E-Cigs <input type="checkbox"/> Hookah <input type="checkbox"/> Chew How much? _____ For how long? _____
<input type="checkbox"/> Yes <input type="checkbox"/> No - Do you smoke marijuana? Do you use <input type="checkbox"/> daily <input type="checkbox"/> several days a week <input type="checkbox"/> weekends <input type="checkbox"/> infrequently
<input type="checkbox"/> Yes <input type="checkbox"/> No - Have you used other recreational drugs besides marijuana in the past 6 months? If yes: what?
<input type="checkbox"/> Yes <input type="checkbox"/> No - Have you ever used prescription medication other than what has been prescribed for you? If so what?
<input type="checkbox"/> Yes <input type="checkbox"/> No - Have you had counseling through the UCSB Alcohol and Drug Program? <input type="checkbox"/> CASE <input type="checkbox"/> SAM <input type="checkbox"/> Other Program
<input type="checkbox"/> Yes <input type="checkbox"/> No - Have you ever received medical care or been hospitalized for alcohol or drug use disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No - Are you in recovery from alcohol or drug addiction? Are you interested in support to lead a sober lifestyle? <input type="checkbox"/> Yes <input type="checkbox"/> No * SBIRT (805) 451-9854

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

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

Sexual History: Three doses HPV vaccine recommended. I have had: <input type="checkbox"/> unknown <input type="checkbox"/> none <input type="checkbox"/> one dose <input type="checkbox"/> two doses <input type="checkbox"/> three doses
<input type="checkbox"/> Yes <input type="checkbox"/> No - Have you ever been sexually active?
<input type="checkbox"/> Yes <input type="checkbox"/> No - Have you had a new sex partner in the past six months?
<input type="checkbox"/> Yes <input type="checkbox"/> No - Do you consistently use condoms for STD protection for: <input type="checkbox"/> oral <input type="checkbox"/> vaginal <input type="checkbox"/> receptive anal <input type="checkbox"/> penetrative anal sex?
How many partners have you had in your lifetime? Number: _____
Have you ever had: <input type="checkbox"/> vaginal sex (Where you are the penetrative partner) <input type="checkbox"/> vaginal sex (Where you are the receptive partner) <input type="checkbox"/> penetrative anal sex <input type="checkbox"/> receptive anal sex <input type="checkbox"/> oral sex
Do you have sex with: <input type="checkbox"/> Men <input type="checkbox"/> Women <input type="checkbox"/> Other _____
What method of birth control do you use? Check all that apply: <input type="checkbox"/> None <input type="checkbox"/> Withdrawal <input type="checkbox"/> External ("male") Condoms <input type="checkbox"/> Oral Contraceptives <input type="checkbox"/> Plan B <input type="checkbox"/> Nuvaring <input type="checkbox"/> Nexplanon/Implanon <input type="checkbox"/> IUD <input type="checkbox"/> Depo Provera <input type="checkbox"/> Internal ("female") Condoms <input type="checkbox"/> Tubal ligation/hysterectomy <input type="checkbox"/> Vasectomy <input type="checkbox"/> Other _____

Patient Signature/Date: _____

Clinician Initials/Date: _____

Revised: February 2018