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)**	
Have you or an immediate blood relative had:	No	Current	Past	✓	Please specify which parent or sibling:
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

Relationship	Age(s)	State of health	Occupation	If deceased, cause of death	Age at death
Parent					
Parent					
Sibling					
Sibling					

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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 - Do you drink alcohol? Average # of drinks per week: _____
☐ 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 passed out or had memory blanks as a result of drinking? ☐ Within past 6 months ☐ More than 6 months ago
☐ Yes ☐ No - Have you had counseling through the UCSB Alcohol and Drug Program? ☐ CASE ☐ SAM ☐ Other Program
☐ 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 received medical care or been hospitalized for substance abuse?
☐ 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 _____

Patient Signature/Date: _____ Clinician Initials/Date: _____

Revised: October 2017