UCSB Student Health Service Confidential Health History

PATIENT NAME_____**PERM#**_____

Birthplace: _____ **Ethnic Origin:** _____ **Major Course of Study:** _____

IN AN EMERGENCY WHO SHOULD WE NOTIFY? NAME: _____ Cell Phone #: _____

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: Please circle if you have had any of the following?	**No**	**Current**	**Past**	**COMMENTS**
1. Serious illnesses / hospitalizations / surgeries				
2. Cancer / leukemia				
3. Diabetes				
4. Thyroid disease				
5. Frequent or severe headaches				
6. Dizziness or fainting spells				
7. Severe head injury				
8. Neurologic disorders / seizures				
9. Eye problems/surgery (not contacts or glasses)				
10. Hearing problems or ear surgery				
11. Allergies, sinus problems				
12. Asthma				
13. Active tuberculosis or positive TB skin test				
14. Severe chest pain / difficulty breathing				
15. Heart problems / heart murmur				
16. High cholesterol				
17. High blood pressure				
18. Blood clots or vein problems				
19. Anemia / blood disorders				
20. Stomach, intestinal problems, ulcer				
21. Chronic or recurrent diarrhea or constipation				
22. Rectal Bleeding				
23. Autoimmune Disorder (e.g. Arthritis, Lupus, Celiac, MS, etc)				
24. Hepatitis / Liver disease				
25. Kidney or Bladder problems / infections				
26. Chronic or recurrent skin disease				
27. Numerous or unusual moles / skin growths				
28. Chronic or recurrent back trouble				
29. ADD/Learning Disabilities				
30. Recent change in weight, increase or decrease				
31. Anorexia / Bulimia / Eating Disorder / Obesity				
32. Followed a special diet				
33. Tried to lose weight by fasting, diet pills, laxatives or vomiting				

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

Relationship	Ages(s)	State of health	Occupation	If deceased, cause of death	Age at death
Father					
Mother					
Sisters					
Brothers					

Safety History:
☐ Yes ☐ No - Do you ever drive a car or ride as a passenger without a seatbelt?
☐ Yes ☐ No - Do you ever talk or text on a handheld phone while driving?
☐ Yes ☐ No – Is there a working smoke detector in your home?
☐ 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

Please complete other side ➡

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? How often? _____ For how long? ____ Do you have a medical marijuana card? ☐ Yes ☐ No
☐ 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 - In the last 6 months, have you felt like you should cut down on your drinking or drug use?
☐ Yes ☐ No - Have you participated in groups or counseling through the UCSB Alcohol and Drug Program? ☐ CASE ☐ SAM ☐ Other
☐ 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 mental health problems (including an eating disorder or substance abuse)?
During the last 2 weeks, have you often been bothered by having little interest or pleasure in doing things? ☐ 0 -not at all ☐ 1 – Several days (3-7days) ☐ 2 – More than half the days (>7days) ☐ 3 – Nearly every day
During the last 2 weeks, have often been bothered by feeling down, depressed or hopeless? ☐ 0 -not at all ☐ 1 – Several days (3-7days) ☐ 2 – More than half the days (>7days) ☐ 3 – Nearly every day
☐ Yes ☐ No - During the past few weeks, have you wished that you were dead?
☐ Yes ☐ No - In the past few weeks, have you felt that you or your family would be better off if you were dead?
☐ Yes ☐ No - In the past few weeks, have you had thoughts of harming or killing yourself?
☐ Yes ☐ No - Have you ever tried to harm or kill yourself?

Sexual History:
Three doses of HPV vaccine recommended. I have had: ☐ unknown ☐ none ☐one dose ☐ two doses ☐ three doses
☐ Yes ☐ No - Have you ever had: ☐ vaginal sex ☐ oral sex ☐ anal sex If no, please skip to the next section.
☐ 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 ☐anal sex?
Do you have sex with: ☐ Men ☐ Women ☐ Both ☐ Other
What method of birth control do you use? Check all that apply: ☐ None ☐ Withdrawal ☐ Condoms ☐ Diaphragm ☐ Plan B ☐ Oral Contraceptives ☐ Nuvaring ☐ Nexplanon/Implanon ☐ IUD ☐ Depo Provera ☐ Tubal ligation/hysterectomy ☐ Vasectomy

Women Only: If you have 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?

Family Health History: Please circle if a family member has ever had any of the following:

	Mom	Dad	Sisters	Brothers	Comments
Allergies / Asthma / Eczema					
Alcoholism/Drug dependency					
Anxiety, Panic Attacks, Depression, Bipolar					
Eating Disorder, other Mental Health issues					
Suicide: □ attempted □ completed					
Cancer					
Diabetes, Kidney problems					
High blood pressure, High cholesterol					
Stroke or heart attack					
Migraines, Thyroid problems					
Tuberculosis, INH treatment for positive TB test					
Other / Hereditary disorders					

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