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