

Hastings College of the Law Student Health Services
PERSONAL HEALTH HISTORY

Name _____ Sex: ___ Birthdate: _____ Applicant/Student ID # _____
 Email Address: _____ Phone # _____

All information is strictly confidential and is released to no one without written permission from the student.
This exam has no bearing on admission status.

Check any of the following that you have had or have currently. Describe, if necessary, under remarks:

- | | | |
|-------------------------------------------------------------------|-------------------------------------------------------------|--------------------------------------------------------------|
| <input type="checkbox"/> Abdominal Cramps | <input type="checkbox"/> Eczema, hives | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Acne, severe | <input type="checkbox"/> Encephalitis | <input type="checkbox"/> Pleurisy |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy, convulsions | <input type="checkbox"/> Problems with Alcohol |
| <input type="checkbox"/> Anxiety, attacks | <input type="checkbox"/> Eye Problems | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting/Blackouts | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Backache, chronic | <input type="checkbox"/> German Measles | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> Bladder, kidney, or testicle problems | <input type="checkbox"/> Hay Fever, allergies, recurrent | <input type="checkbox"/> Sickle Cell |
| <input type="checkbox"/> Bleeding or clotting disorder, phlebitis | <input type="checkbox"/> Headaches (frequent and/or severe) | <input type="checkbox"/> Sinus Infection |
| <input type="checkbox"/> Breast lump, tumor, discharge | <input type="checkbox"/> Head Injury | <input type="checkbox"/> Skin Problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hearing Difficulty | <input type="checkbox"/> Sore Throats, frequent |
| <input type="checkbox"/> Colds, frequent | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Cough, chronic | <input type="checkbox"/> Hernia/Rupture | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Ulcer, stomach, gallbladder prob. |
| <input type="checkbox"/> Diarrhea, chronic | <input type="checkbox"/> Immune System Problem | <input type="checkbox"/> Ulcerative colitis, Crohn's, polyps |
| <input type="checkbox"/> Digestive Upsets | <input type="checkbox"/> Infectious Mononucleosis | <input type="checkbox"/> Vomiting, repeated |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Intestinal Parasite Infection | <input type="checkbox"/> Warts |
| <input type="checkbox"/> Drug Abuse | <input type="checkbox"/> Joints, disease/injury | <input type="checkbox"/> Weight gain or loss |
| <input type="checkbox"/> Eating Disorders | <input type="checkbox"/> Meningitis | |

List any operations or other hospitalizations (when/what/where) **and any other serious illnesses/injuries** not listed above, and/or provide details to YES response(s) above.

List current medications including birth control pills, supplements, vitamins:

Describe any exposure to occupational/environmental hazards: _____

Do you currently or have you in the past used tobacco products? currently past never used tobacco products
 Check all that apply: smokeless tobacco cigars pipe cigarettes/day ___packs/day ___ yrs. smoked/used

In the past year did you drink alcohol? No Yes If Yes:

Check average/typical use none 1 or fewer 2-3 4-5 more than 5 drinks/day drinks/week

What do you do to relieve stress? _____

Please describe your general state of health now: _____

Please describe any physical, mental, or emotional problems not mentioned above: _____

FAMILY HISTORY: Has any member of your family ever had any of the following? Please check :

- | | | | | |
|------------------------------------------|-------------------------------------------|----------------------------------------------|----------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> Allergy, Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Migraine | <input type="checkbox"/> Mental Health probs. |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Drinking Probs. | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Stomach prob. | <input type="checkbox"/> Other |
| <input type="checkbox"/> Blood diseases | <input type="checkbox"/> Epilepsy. | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> No health problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Thyroid dz. | <input type="checkbox"/> Unknown family history |
| <input type="checkbox"/> Chem Dep | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Tuberculosis | |

*If you use recreational drugs, please discuss confidentially with Student Health Services medical provider.