UCSD STUDENT HEALTH SERVICE 0039, 9500 GILMAN DRIVE, LA JOLLA, CA 92093-0039 (858) 534-3300

Please read and complete this form. The information is for the use of Student Health Service. It is protected, confidential information intended for your medical care.

STUDENT INFORMATION

Print Name (Last, First, Middle)

☐ Male ☐ Female
☐ M → F ☐ F → M

SSN

Date of Birth | Place of Birth | College | Major

☐ Single ☐ Married ☐ Separated/Divorced ☐ Widowed | ☐ Undergrad ☐ Grad ☐ Medical School ☐ Pharmacy ☐ Business School

Local / S.D. Address | City | State | Zip

Local phone or cell phone | OK to leave phone message? ☐ Yes ☐ No | Email address | OK to leave email message? ☐ Yes ☐ No | *Please be aware that email may not be confidential*

Insurance Carrier ☐ SHIP ☐ Other (please specify)

PARENT/GUARDIAN/NEXT OF KIN INFORMATION

Name | Relationship | Home Phone | Alternate Phone

Address | City | State | Zip

EMERGENCY CONTACT (if other than above)

Name | Relationship | Home Phone | Alternate Phone

Address | City | State | Zip

PLEASE MARK BOX IF RESPONSE IS YES. LEAVE BOX OPEN FOR NO

PAST MEDICAL HISTORY - Have you ever had?

STAFF NOTES

☐ allergies/hay fever	☐ colitis	☐ kidney problem	☐ seizures
☐ anemia/blood disorder	☐ deafness	☐ liver problem/hepatitis	☐ sexually trans. infection ____
☐ anorexia/bulimia	☐ depression	☐ malaria	☐ thyroid problem
☐ anxiety or panic disorder	☐ diabetes	☐ mental illness (other)	☐ tuberculosis (active)
☐ arthritis	☐ gall bladder disease	☐ ovarian cysts	☐ ulcer/stomach problems
☐ asthma	☐ headaches (frequent or severe)	☐ pelvic infections	☐ other/list ____
☐ cancer	☐ heart problem	☐ pneumonia	____
☐ cerebral palsy/stroke	☐ high blood pressure	☐ pneumothorax	
☐ chickenpox	☐ high cholesterol	☐ rheumatic fever	

HOSPITALIZATION/SURGERY

☐ NO ☐ YES, please specify date and reason:

Are you currently under the care of a medical or psychiatric provider? ☐ YES ☐ NO
(please list names and specialty)

CURRENT MEDICATIONS

☐ NO ☐ YES, please specify:

ALLERGIES

☐ NO known allergies ☐ YES, as specified:

☐ penicillin ☐ sulfa ☐ codeine ☐ aspirin/ibuprofen ☐ other drugs ____

☐ bee sting ☐ latex ☐ food allergy ____

Please specify the type of allergic reaction (symptoms) that you had: ____

OFFICE USE ONLY

REV. BY	DATE

CONTINUE ON OTHER SIDE

TUBERCULOSIS TEST: It is recommended that all students provide evidence of either a recent skin test or chest x-ray.

TB Skin Test (Mo/Yr) IF POSITIVE: Chest x-ray (Mo/Yr) MEDICATION TAKEN:

Result: ☐ Neg ☐ Pos Result: DATE STARTED: DATE FINISHED:

TETANUS Date of last immunization: **HEPATITIS B** Have you completed the series of 3? ☐ Yes ☐ No

FAMILY HISTORY Any parent, grandparent, or sibling with the following:

	Which Family Member (s)		Which Family Member (s)
☐ anemia/blood disorder		☐ high blood pressure	
☐ anxiety disorder		☐ high cholesterol	
☐ arthritis		☐ other mental illness	
☐ asthma/allergies		☐ stroke	
☐ cancer		☐ suicide	
☐ clotting disorder		☐ thyroid disorder	
☐ depression		☐ ulcers	
☐ diabetes		☐ tuberculosis	
☐ epilepsy/seizure		☐ other	
☐ heart disease			

HABITS AND SOCIAL ISSUES

What is your current height? ________ current weight? ________

Do you have concerns about your current weight? ☐ Yes ☐ No
Concerns ____________________

Do you have concerns about your current diet and exercise habits? ☐ Yes ☐ No
Concerns ____________________

Do you use tobacco? ☐ Yes ☐ No
If yes, amount/day ____________ #years of use ________

Do you drink alcohol? ☐ Yes ☐ No
If yes, estimated days per month you drink ________
How often do you drink 4 or more drinks on one occasion? ________

Do you use recreational drugs? ☐ Yes ☐ No
If yes, which ones? ____________________

Are you sexually active? ☐ Yes ☐ No ☐ Yes, in the past, but not currently

If yes,
Have your partners been: ☐ Male ☐ Female
What method of contraception are you using? ☐ None ☐ Don't need
____

Do you use protection against STD's? ☐ Always ☐ Sometimes ☐ Never ☐ N/A

Are you often bothered by feeling down, depressed, or hopeless? ☐ Yes ☐ No

Do you currently experience stress or anxiety that significantly interferes with your life? ☐ Yes ☐ No

STAFF NOTES

☐ Health ed provided

☐ Referral

☐ F/U appt. advised

if +, SI? ☐ Yes ☐ No

RN initial	DATE

PLEASE DISCUSS WITH YOUR PROVIDER IF YOU ARE CURRENTLY IN A RELATIONSHIP WHERE YOU ARE BEING PHYSICALLY HURT (SUCH AS HIT, KICKED, OR PUNCHED) OR ARE FEARFUL FOR YOUR SAFETY.

I CERTIFY THAT TO THE BEST OF MY KNOWLEDGE, THE INFORMATION ON THIS FORM IS COMPLETE AND ACCURATE.

DATE ____________________ STUDENT SIGNATURE ____________________