

HEALTH INVENTORY AND HISTORY

Your answers to the following questions will be kept strictly confidential and will be used to help us with your health care.

PLEASE PRINT

Name (Last, First): _____ M F DOB ____/____/____

Marital Status: Single Partnered Married Separated Divorced Widowed

Are you currently employed? Yes No

If yes, type of work you do: _____

University Major: _____

Previous or Current Doctor/Clinic: _____

Health Insurance: _____

Ethnicity/Race/Cultural Background: _____

HEALTH HISTORY

Allergies: _____

List All Diagnosed Significant Medical Problems And Surgeries That You Have Had:

HEALTH HABITS AND PERSONAL SAFETY

Exercise:

Sedentary (No exercise) Mild Exercise Occasional Vigorous Exercise Regular Vigorous Exercise

Diet:

Do you feel that your diet is healthy? Yes No

Are you interested in dietary or nutrition advice? Yes No

Alcohol:

Do you drink alcohol? Yes No

If yes, typically what kind and how many drinks per week? _____

Are you concerned about the amount you drink? Yes No

Do you "binge" drinking? Yes No

Do you drive after drinking? Yes No

Tobacco:

Do you use tobacco? Yes No

If yes, in what form (cigarettes, cigars) and how often? _____

Drugs:

Do you use recreational or street drugs? Yes No

Have you ever injected recreational or street drugs? Yes No

Personal Safety:

Do you always wear a seatbelt when you are driving? Yes No

We at the SHC are concerned about verbal, physical, and sexual abuse issues and their impact on our patients. Would you like to discuss this issue with us? Yes No



California State University, Los Angeles
STUDENT HEALTH CENTER

HEALTH INVENTORY AND HISTORY

Last Name _____

First _____

CIN _____

Sex:

Are you sexually active? Yes No

If yes, are you trying to get pregnant? Yes No

If not trying to get pregnant, what type of contraception are you using?_____

Have you ever had a sexually transmitted disease? Yes No

We at the SHC are concerned about preventing Human Immunodeficiency Virus (HIV) and Hepatitis. Would you like to speak with us about your risk of acquiring HIV and Hepatitis? Yes No

MENTAL HEALTH

Are you depressed? Yes No

Do you have or have you had an eating disorder (anorexia, bulimia)? Yes No

Have you ever attempted suicide?..... Yes No

WOMEN ONLY

How often do you have a period _____

Do you think your periods are "normal"? Yes No

If no, explain _____

Number of pregnancies _____ Number of live births _____

Any urinary tract, bladder or kidney infections within the last year? Yes No

Any recent breast lumps or unusual nipple discharge? Yes No

Date of last pap smear: _____ Was it normal?..... Yes No

If over 40, date of last mammogram _____

Do you perform self breast exams?..... Yes No

MEN ONLY

Do you examine your testicles for lumps/masses? Yes No

Any problems with sexual function (impotence, ejaculation)? Yes No

If over 50, have you had your prostate checked (PSA, exam)? Yes No

Patient's Signature

Date

Reviewer's Signature

Date



California State University, Los Angeles
STUDENT HEALTH CENTER

HEALTH INVENTORY AND HISTORY

Last Name _____

First _____

CIN _____