Channel Islands
CALIFORNIA STATE UNIVERSITY

Student Health Services
Medical History Form

Name:_____ **Date**:_____ **Age**:_____ **Date of Birth**:_____

(The following information is confidential and will be used only by your medical provider to enhance the level of personal care.)

- Are you allergic to any medications? ☐ Yes ☐ No
  - If yes, please list medication and reaction:_____
- Are you currently taking over-the-counter medications, prescription medicines (including birth control), vitamins, supplements or homeopathic remedies? ☐ Yes ☐ No
  - If yes, please list:_____
- Do you have a primary care provider outside of this location? ☐ Yes ☐ No
  - If yes, please provide: Name-_____ Phone-_____
- Has a **family** member (parent, grandparent or sibling) ever been diagnosed with any of the following?

1. ☐ Heart attack/disease
2. ☐ Stroke
3. ☐ Blood clot in legs/lungs
4. ☐ High blood pressure
5. ☐ High cholesterol
6. ☐ Diabetes
7. ☐ Alcohol/drug abuse
8. ☐ Genetic disorders/birth defects
9. ☐ Mental illness
10. ☐ Cancer
11. ☐ I do not know my family history.

- Have **YOU** ever had problems with any of the following? (Please check all that apply)

1. ☐ Heart disease
2. ☐ High blood pressure
3. ☐ Stroke
4. ☐ Diabetes
5. ☐ High cholesterol
6. ☐ Tuberculosis (TB)
7. ☐ Asthma
8. ☐ Blood clot in legs/lungs
9. ☐ Bleed/bruise easily
10. ☐ Anemia
11. ☐ Sickle cell disease
12. ☐ Kidney/bladder problems
13. ☐ Seizures/epilepsy
14. ☐ Depression
15. ☐ Suicidal thoughts
16. ☐ Mental illness
17. ☐ Headaches/migraines
18. ☐ Liver problems/hepatitis
19. ☐ Gall bladder disease
20. ☐ Eating disorder
21. ☐ Cancer: Type-_____
22. ☐ Thyroid disease
23. ☐ Infertility

- Have you ever been hospitalized or had surgery? ☐ Yes ☐ No
  - If Yes, please list when and why:_____
- Have you ever received a blood transfusion? ☐ Yes ☐ No
- Please indicate whether you have received the following immunizations:

Measles, Mumps, and Rubella (MMR)	☐ Yes	☐ No	☐ I do not know	
Hepatitis B (HBV)	☐ Yes	☐ No	☐ I do not know	
Human Papilloma Virus (HPV)	☐ Yes	☐ No	☐ I do not know	
Tetanus/Pertussis (Td/Tdap)	☐ Yes	☐ No	☐ I do not know	Date: _____

- Please complete the following questions regarding **habits/ lifestyle choices**:
  1. How many alcoholic beverages do you consume in an average week? _____
  2. Do you smoke cigarettes? ☐ Yes ☐ No If yes, how many per day? _____
  3. Do you use recreational drugs? ☐ Yes ☐ No If yes, please list: _____
  4. Have you ever used intravenous drugs? ☐ Yes ☐ No If yes, have you ever shared needles? ☐ Yes ☐ No
  5. Has anyone ever told you that you have a problem with drugs or alcohol? ☐ Yes ☐ No
  6. Is anyone, including your partner, threatening you, causing you fear or hurting you physically? ☐ Yes ☐ No

- Please complete the following questions regarding **sexual history/ reproductive health**:

1. Have you ever been pressured or forced to have sex when you did not want to? ☐ Yes ☐ No
2. Have you ever had a sexual partner with a history of ☐ Injected drug use or ☐ HIV? ☐ Yes ☐ No (Please Indicate)

- **In the past 12 months…**

3. Have you been sexually active? ☐ Yes ☐ No If yes, how many sexual partners have you had?_____
4. Who have you had sex with? ☐ Men ☐ Women ☐ Both
5. Have you participated in any of the following? ☐ Oral sex ☐ Anal sex ☐ Vaginal sex
6. Do you think that your partner currently has other sexual partners? ☐ Yes ☐ Not sure, possibly ☐ No, unlikely
7. Have you or your sexual partner(s) had any of the following? (Check all that apply)

A. ☐ Chlamydia
B. ☐ Gonorrhea
C. ☐ Genital Herpes
D. ☐ Trichomoniasis (Trich)
E. ☐ Pelvic Inflammatory Disease
F. ☐ Genital Warts
G. ☐ Bacterial Vaginitis (BV)
H. ☐ Syphilis
I. ☐ Other: _____

8. How important is it for you to avoid pregnancy at this time? ☐ Very ☐ Somewhat ☐ Not at all
9. What birth control methods have you/ your partner(s) used in the past? (Check all that apply)

A. ☐Condoms/rubbers
B. ☐ Birth control pills
C. ☐DepoProvera/shot
D. ☐ OrthoEvra/patch
E. ☐ IUD (Paragard/Mirena)
F. ☐ NuvaRing (vaginal ring)
G. ☐Implanon (Implant)
H. ☐Diaphragm/Cervical cap
I. ☐ Tubal Ligation/Vasectomy
J. ☐ Abstinence
K. ☐Foam/film/jelly
L. ☐ Withdrawal/pulling out
M. ☐ Rhythm method
N. ☐ None

10. What birth control method are you using with your current partner(s)? _____
11. Are you happy with your current method? ☐ Yes ☐ No
12. How often do you use condoms? ☐ Always ☐ Sometimes ☐ Never
13. How old were you when you became sexually active? _____ ☐ I have not become sexually active yet.
14. Are you/ your partner(s) planning to get pregnant in the next two years? ☐ Yes ☐ No ☐ Maybe
15. Have you ever had an HIV screening test? ☐ Yes ☐ No
    - If yes, when was your last one? _____ Results? ☐ Positive ☐ Negative

- **Male:** (Female: skip to next section)

1. Have you ever had a genital exam? ☐ Yes ☐ No If yes, when was your last one?_____
2. Have you ever been told there was a problem? ☐ Yes ☐ No If yes, what was it?_____

- **Female:** (Male: skip to previous section)

1. How old were you when you first had vaginal intercourse? _____ ☐ Never had vaginal intercourse.
2. Have you ever had a Pap smear? ☐ Yes ☐ No If yes, when was your last one? _____
3. Have you ever had an **abnormal** Pap smear? ☐ Yes ☐ No If yes, when was your last one? _____
4. Have you ever had? ☐ Fibroids ☐ Ovarian cysts ☐ Endometriosis ☐ Other_____☐ None of the previous
5. Have you ever had a mammogram? ☐ Yes ☐ No
    - If yes, when was your last one? _____ Results? ☐ Normal ☐ Abnormal
6. How old were you when you started your period? _____
7. Your period comes every _____ days and lasts _____ days.
8. Your periods are (check all that apply): ☐ Regular ☐ Irregular ☐ Painful ☐ Light ☐ Moderate ☐ Heavy
9. Do you have spotting or bleeding between periods? ☐ Yes ☐ No
10. Have you ever used emergency contraception (Plan B/ morning after pill)? ☐ Yes ☐ No
11. Please list the number of the following: ____ Pregnancies, ____ Live births, ____ Abortions, ____Miscarriages

- Is there anything else about your health or sexual practices that you would like to discuss with the provider? _____

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