campus HEALTH

Date completed: _____/_____/_____

PERSONAL INFORMATION

Legal Name *(Last, First, MI)*: _____ DOB: ___/____/____ PID: _____

Preferred Name: _____ Pronouns: _____

Gender assigned at birth: ○ Male ○ Female ○ Other: _____

Gender identity: ○ Male ○ Female ○ Transgender Man/Transgender Male ○ Transgender Woman/Transgender Female

○ Other *(please specify)*:_____ ○ Prefer not to respond

Reason for visit today: _____

MEDICATIONS List with doses. Include contraceptives (pill, IUD, Nexplanon), vitamins, supplements, etc. ○ None

_____ _____

_____ _____

_____ _____

ALLERGIES List medication, food, insect or latex allergies and the type of reaction you had ○ I have no drug allergies

_____ _____

_____ _____

SURGERIES AND HOSPITALIZATIONS List what types and dates ○ None

_____ _____

_____ _____

SOCIAL HISTORY AND EXERCISE

Do you use tobacco? ○ No ○ Yes, what form? ○ cigarettes ○ cigars ○ e-cigs (JUUL) ○ smokeless tobacco
How many per day? _____ For how long? _____
Frequency of use? ○ daily ○ weekly ○ monthly ○ socially ○ rarely
Past history of smoking? ○ No ○ Yes Date quit: _____

Do you drink alcohol? ○ No ○ Yes, how many times a week? _____ How many drinks per sitting? _____
History of alcohol abuse? ○ No ○ Yes

Do you use, or have you ever used recreational drugs? ○ No ○ Yes, describe: _____

Do you get regular exercise? ○ No ○ Yes, what kind of exercise? _____
How often? ○ 1-2 times per week ○ 3-4 times per week ○ 5-6 times per week ○ Daily
Duration per session? ○ <15 min ○ 15-30 min ○ 30-45 min ○ 45-60 min ○ >60 min

Do you have any dietary restrictions? ○ No ○ Yes, what kind? _____

SEXUAL HISTORY

Do you have sex with: ○ Men ○ Women ○ Both ○ Other: _____ ○ Never Sexually Active

Are you interested in STI screening today? ○ No ○ Yes When was your last STI screening? _____

Any new partner(s) since your last STI screening? ○ No ○ Yes

Have you ever had a sexually transmitted infection? ○ No ○ Yes, what type and when? _____

How much of the time do you use condoms and/or dental dams? ○ Never ○ Sometimes ○ Always ○ Almost always

Do you feel unsafe, or have you ever been harmed in a physical, emotional or sexual manner? ○ No ○ Yes

GYNECOLOGICAL AND OBSTETRIC HISTORY

Age at first period? _____ Periods are: ○ regular ○ irregular Period comes every how many days? _____

Period usually lasts how many days? _____ Do you bleed between your cycles? ○ No ○ Yes

Menstrual flow is: ○ light ○ moderate ○ heavy Menstrual cramps are: ○ mild ○ moderate ○ severe

Do you use contraception? ○ No ○ Yes, what kind? _____ For how long?_____

Have you ever been pregnant? ○ No ○ Yes, # of births: ___ ; abortions ___; miscarriages ___ ; ectopic pregnancies _____

Date of last Pap and result? _____

History of abnormal Pap? ○ No ○ Yes, date_____ History of colposcopy or LEEP? ○ No ○ Yes, date_____

YOUR MEDICAL CONDITIONS (check all that apply)

- ☐ ADHD
- ☐ Anemia
- ☐ Anxiety or Depression
- ☐ Asthma
- ☐ Blood transfusion
- ☐ Cancer *(type)* _____
- ☐ Clotting disorder
- ☐ Crohn's or Ulcerative Colitis
- ☐ Diabetes mellitus (type) ____
- ☐ Eating disorder
- ☐ Epilepsy (Seizures)
- ☐ Heart disease or condition
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ HIV/AIDS
- ☐ Kidney stone or disease
- ☐ Liver disease, hepatitis, tumor
- ☐ Lupus (SLE)
- ☐ Migraine headaches
- ☐ Rheumatoid arthritis (RA) or (JRA)
- ☐ Sickle cell anemia
- ☐ Stroke or TIA
- ☐ Thyroid disorder
- ☐ Other:_____

FAMILY MEDICAL CONDITIONS (check all that apply)

	Breast Cancer	Colon Cancer	Ovarian Cancer	Prostate Cancer	Diabetes	Heart Disease	High Cholesterol	High Blood Pressure	Joint disease	Kidney Disease	Mental Illness	Migraine	Stroke	Thyroid Disease	Other
Father															
Mother															
Sibling(s)															
Paternal grandfather															
Paternal grandmother															
Maternal grandfather															
Maternal grandmother															
Other:_____															