campus HEALTH

Date completed: _____/_____/_____

PERSONAL INFORMATION

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

Preferred Name: _____ Pronouns: _____

Sex assigned at birth: ○ Female ○ Male ○ Intersex / Ambiguous

How do you describe yourself? ○ Female ○ Male ○ Trans Female ○ Trans Male ○ Genderqueer / non-conforming

○ 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

Alcohol

Do you ever drink alcohol? ○ No ○ Yes, how many times a **week**? _____ How many drinks per sitting? _____

Tobacco and drugs

Do you use tobacco (cigarettes, cigars, hookah, pipe, bidis, kreteks) ○ No ○ Yes, what type(s)? _____

Do you use smokeless tobacco (chewing, snuff, dip, dissolvable) ○ No ○ Yes, what type(s)? _____

Do you use e-cigs such as vaping ○ No ○ Yes

How many times a **week** do you use ***any*** of the above? _____

Do you use recreational drugs? ○ No ○ Yes, what type of drug(s): _____

How many times a **week** do you use ***any*** of the above? _____

Lifestyle and Diet

On average, how many days a **week** do you engage in moderate to strenuous exercise?

○ 1-2 times a week ○ 3-4 times a week ○ 5-6 times a week ○ Daily

On average, how many minutes do you engage in exercise at this level:

○ <15 min ○ 15-30 min ○ 30-45 min ○ 45-60 min ○ >60 min ○ >90

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

SEXUAL HISTORY

Are you having **any** kind of sex (oral, vaginal, or anal) with anyone, currently? ○ No ○ Yes ○ Never been sexually active

What parts of **your** body do you use when having sex? ○ Mouth ○ Vagina ○ Penis ○ Anus/Rectum

Do you partner with people who have ○ Penises ○ Vaginas ○ Other (please specify) _____

Have you **ever** been diagnosed with STI? ○ No ○ Yes, what type and when? _____

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

How much of the time do you use condoms and/or dental dams? ○ Never ○ Sometimes ○ Almost always ○ 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 Do you bleed between your cycles? ○ No ○ Yes

Period comes every how many days? _____ Period usually lasts how many days? _____

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

Have you ever been pregnant? ○ No ○ Yes, # of births: _____; abortions ____; miscarriages _____; ectopics _____

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

Date of last Pap result? _____ History of abnormal Pap(s)? ○ No ○ Yes, date(s) _____

YOUR MEDICAL CONDITIONS (check all that apply)

- ☐ Anemia
- ☐ Anxiety/Depression/Bipolar
- ☐ Asthma
- ☐ Autoimmune disease
- ☐ Cancer *(type)* _____
- ☐ Crohn's or Ulcerative Colitis
- ☐ Diabetes mellitus (type) ____
- ☐ DVT or PE
- ☐ Eating disorder
- ☐ Epilepsy (Seizures)
- ☐ Heart disease or condition
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Kidney stone or disease
- ☐ Liver disease, hepatitis, tumor
- ☐ Migraine headaches
- ☐ Thyroid disorder
- ☐ Other: _____

FAMILY MEDICAL CONDITIONS (check all that apply)

	Cancer(s) (please list type)	Autoimmune disease(s)	Diabetes	Early Death(s)	Heart Disease	High Cholesterol	High Blood Pressure	Kidney Disease	Mental Illness	Migraines	Stroke	Thyroid Disease	Other (please list type)	Other (please list type)
Father														
Mother														
Sibling(s)														
Paternal grandfather														
Paternal grandmother														
Maternal grandfather														
Maternal grandmother														
Other: _____														