

Client Health History

Student Health Services • Curry Hall, Room 131 • (505) 562-2321

Full Name: _____
Last First Middle

Date of Birth: _____
Month/Day/Year

Anything that you write in this questionnaire is part of your medical record. Your medical record is confidential except when we are required by law to report child abuse or neglect, plans of suicide or homicide. For good, safe medical practice we report to your parent or guardian, serious medical conditions that require urgent medical intervention.

If you are unsure about any question, leave blank and ask the nurse for help.

Allergies to drugs: _____ Over-the-counter medications/vitamins/herbs: _____

Allergies to other substances: _____ Prescription medications: _____

Date of last tetanus shot: _____ Fever 101°F or chills in the last two weeks: _____

Date of last measles/rubella shot (MMR): _____ Date of last Hepatitis B shot: _____

Personal Medical History (anything you have ever had)

- | | |
|--|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No High blood pressure/stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No Anemia (low blood or low iron) |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Heart problems
(ex. heart attack, rheumatic fever, heart murmur) | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you protect yourself from HIV/AIDS/STD?
How: _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No High cholesterol/triglycerides | <input type="checkbox"/> Yes <input type="checkbox"/> No Ever had an AIDS test?
If yes, when: _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes (high sugar) | <input type="checkbox"/> Yes <input type="checkbox"/> No Sexually transmitted infection
(chlamydia, herpes, gonorrhea) |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Thyroid disease/goiter | <input type="checkbox"/> Yes <input type="checkbox"/> No Pelvic infection (uterus/tubes) |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Liver disease/hepatitis/mononucleosis | <input type="checkbox"/> Yes <input type="checkbox"/> No Men: problems with the penis, testicles, prostate,
pain with sex, sores on genitals, hurts to pee or itching |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Gallbladder disease/gallstones | <input type="checkbox"/> Yes <input type="checkbox"/> No Surgery or stayed in a hospital |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Birth defects/sickle cell anemia or trait | <input type="checkbox"/> Yes <input type="checkbox"/> No Mother took hormones (DES) while pregnant
with you |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Ulcers/stomach problems
(frequent pain and/or heartburn) | <input type="checkbox"/> Yes <input type="checkbox"/> No Frequent vaginal infections (yeast, bacterial) |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney disease/bladder | <input type="checkbox"/> Yes <input type="checkbox"/> No Do you wear a seatbelt while driving or riding |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Lung disease/asthma/TB | <input type="checkbox"/> Yes <input type="checkbox"/> No Were you born in a foreign country?
Where: _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No Have you been out of the US? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Breast lump, discharge | <input type="checkbox"/> Yes <input type="checkbox"/> No Tattoos or body piercing |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Blood clot in a leg or lung | <input type="checkbox"/> Yes <input type="checkbox"/> No Wear glasses/contacts |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Varicose Veins | <input type="checkbox"/> Yes <input type="checkbox"/> No Vision changes (blurry vision, flashing lights, etc.) |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Seizures/convulsions | <input type="checkbox"/> Yes <input type="checkbox"/> No Skin problems/acne |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Severe headaches/migraines | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Depression/anxiety disorder/eating disorder | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Blood transfusion | |

Notes: _____

Family Health History (illnesses of grandparents/parents/brothers/sisters, living or dead)

- | | |
|--|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Heart disease/heart attacks before age 50 | <input type="checkbox"/> Yes <input type="checkbox"/> No Other cancer |
| <input type="checkbox"/> Yes <input type="checkbox"/> No High blood pressure/stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No Birth defects |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes (high sugar) | <input type="checkbox"/> Yes <input type="checkbox"/> No Lung disease (cancer, emphysema, TB) |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cancer of the breast, and or ovaries | <input type="checkbox"/> Yes <input type="checkbox"/> No Alcoholism and/or drug addiction |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Depression | |

Notes: _____

Vast Questionnaire

- Yes No Has anybody ever hit, kicked, punched, pushed, choked, slapped, threatened, forced sex, sexually abused, raped or otherwise hurt you or your child?
- Yes No Have you ever hit, kicked, punched, pushed, choked, slapped, threatened, forced sex, sexually abused or otherwise hurt anyone?
- Yes No Do you keep a gun in the house and is it properly secured so that young people don't have unsupervised access to it?
- Yes No Do you drink alcohol, including beer, wine or distilled spirits?
On average, how many days per week do you drink alcohol? _____
On a typical day when you drink, how many drinks do you have? _____
What is the maximum number of drinks you have had on any give occasion during the last month? _____
- Yes No Which of these drugs have you used in the last year? Pot, heroin, cocaine, inhalants, amphetamines, crack, ecstasy, steroids, GHB, or any other drug? _____
- Yes No Do you misuse any medications?
- Yes No Have you ever injected drugs? If yes, how much? _____
- Yes No Have you had any sexual partners that were gay, bisexual or shot drugs?
- Yes No Do you smoke? If yes, how much? _____
- Yes No Do you use tobacco products of any form? If yes, what? _____
- Yes No Are you exposed to the smoke of others?
- Yes No Over the past two weeks, have you felt down, depressed or hopeless?
- Yes No Over the past two weeks have you felt little interest or pleasure in doing things?

OB/GYN History

About your periods:

- Age when first period started: _____ How many days between the start of one period and the start of the next period: _____
- How many days do your periods last: _____ How much do you bleed: Heavy Medium Light Cramps: Yes No
- Yes No Have you ever had sexual intercourse? Your age the first time you had intercourse: _____

About your pap smears:

- Last pap smear date: _____ Results: _____
- Yes No Any abnormal results ever? If yes, when: _____

Present Problems (are you having any problems):

- Yes No Vaginal itching/burning/dryness Yes No Unusual or bad smelling vaginal discharge
- Yes No Spotting or bleeding between periods Yes No Other sex problems or problems of any kind?
- Yes No Trouble holding your urine?

Pregnancy prevention:

- How do you prevent pregnancy? _____
- What other method do you want to use? _____
- What other method have you used? _____
- Problems with any method you used? _____
- When do you want to become pregnant? _____

About Pregnancies:

- Total number of pregnancies: _____ Number of live births _____ Premature—less than 36 weeks or eight months: _____
- Abortions: _____ Miscarriages/stillborn: _____ C-sections: _____
- Yes No Problems with any pregnancy? (if yes, please describe below) Date of last delivery: _____
- If within the past three months, write date and location of postpartum exam: _____
- Yes No Are you breast feeding? Problems with breast feeding? Yes No
- Birth weight of smallest baby? _____ Birth weight of largest baby? _____

Notes: _____

Patient's Signature: _____ Date: _____

Staff: _____ Date: _____ Staff: _____ Date: _____