

THE EVERGREEN STATE COLLEGE HEALTH CENTER
Student Health Questionnaire

Initial Date: _____
 Reverification Date (Qtrly) _____
 Reverification Date (Qtrly) _____

This questionnaire is designed to provide a comprehensive overview of your health. It provides important information that will help the medical team give you specific, personalized care & information about how to stay healthy. This information is strictly confidential & you do not have to answer any questions that make you uncomfortable.

Name _____ A# _____ Date of _____ / _____ / _____
Last First MI Birth Month Day Year

Are you **ALLERGIC** to any **medications**? YES NO
 If yes, name the drug and describe what happens? _____
 Have you ever had a life-threatening allergic reaction (**anaphylaxis**) YES NO To what? _____

Current Medications: _____
 (include birth control pills, herbs, & vitamins)

Medical History (important illnesses and operations, include the year) _____

Personal Health History – Check ALL Past or Current	Family Health History – Check ALL that apply
<input type="checkbox"/> Allergies: (circle) Food Dust Animals Latex	<input type="checkbox"/> Adopted with no knowledge of biological health history
<input type="checkbox"/> Asthma	<input type="checkbox"/> Biological mother: Age if living _____ Age if deceased _____
<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Biological father: Age if living _____ Age if deceased _____
<input type="checkbox"/> Cancer	<input type="checkbox"/> Number brothers _____ Number sisters _____
<input type="checkbox"/> Chlamydia	Please note which family member (mother, father, paternal or maternal grandparents or sibling) has had the following? <input type="checkbox"/> I have reviewed the items & none apply to my family.
<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Alcoholism
<input type="checkbox"/> Gastrointestinal Disorder	<input type="checkbox"/> Bleeding Disorders
<input type="checkbox"/> Genital Warts	<input type="checkbox"/> Breast Cancer
<input type="checkbox"/> Gonorrhea	<input type="checkbox"/> Cancer
<input type="checkbox"/> Severe Headache (migraine)	<input type="checkbox"/> Depression
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Hepatitis: A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/>	<input type="checkbox"/> Drug Problem
<input type="checkbox"/> Herpes	<input type="checkbox"/> Heart Attack (before age 55)
<input type="checkbox"/> Learning Disability	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Mental Health Diagnosis: <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Suicide Attempt <input type="checkbox"/> Mental Health Hospitalization	<input type="checkbox"/> High Cholesterol
<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Sickle Cell Anemia
<input type="checkbox"/> Positive TB test	<input type="checkbox"/> Stroke
<input type="checkbox"/> Thyroid Condition	<input type="checkbox"/> Suicide
<input type="checkbox"/> Other	<input type="checkbox"/> Thyroid Condition
<input type="checkbox"/> I have reviewed the info and no items apply to me	<input type="checkbox"/> Other

General Health & Well-being Check those that apply	General Health and Well-being Review Date
	<input type="checkbox"/> No Changes since _____ I have reviewed the items. <input type="checkbox"/> No Changes since _____ I have reviewed the items.
How would you describe your general health ? <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	
Over the PAST TWO WEEKS , how often have you been bothered by: Little interest or pleasure in doing things. <input type="checkbox"/> 0 – not at all <input type="checkbox"/> 1= several days <input type="checkbox"/> 2 = more than half the days <input type="checkbox"/> 3 = nearly every day Feeling down, depressed or hopeless. <input type="checkbox"/> 0 – not at all <input type="checkbox"/> 1= several days <input type="checkbox"/> 2 = more than half the days <input type="checkbox"/> 3 = nearly every day	
Exercise – Check those that apply	
<input type="checkbox"/> Exercise? What type? _____ Times per week _____ For how long _____	
Safety – Check those that apply	
<input type="checkbox"/> Working smoke detector at home	
<input type="checkbox"/> Fire extinguisher at home	
<input type="checkbox"/> Have a firearm or access to a firearm (circle)	
<input type="checkbox"/> Use a seatbelt while in a car	
<input type="checkbox"/> Use a helmet while on a motorcycle or bicycle	
<input type="checkbox"/> Know how to swim	
<input type="checkbox"/> Know CPR	
Diet – Check those that apply	
<input type="checkbox"/> Vegetarian	
<input type="checkbox"/> Vegan	
<input type="checkbox"/> Special diet (specify) _____	
<input type="checkbox"/> Caffeine intake (coffee, tea, other) _____ Cups per day	

Social History – Check those that apply	Social History – Review
	<input type="checkbox"/> No Changes since _____ I have reviewed the items. <input type="checkbox"/> No Changes since _____ I have reviewed the items.
Are you: <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Divorced / Separated <input type="checkbox"/> Other _____	
<input type="checkbox"/> Current Work Work-related Risks _____	
<input type="checkbox"/> Hobbies	
<input type="checkbox"/> Travel, last 12 months	
<input type="checkbox"/> Spiritual/Religious Practice _____	
Check if any of the following are of concern:	
<input type="checkbox"/> Height/Weight	
<input type="checkbox"/> Body Shape	
<input type="checkbox"/> Excessive shyness	
<input type="checkbox"/> Few friends	
<input type="checkbox"/> Pressure to conform	
<input type="checkbox"/> Violence/Arguments in Relationships	
<input type="checkbox"/> Questions about Sexually Transmitted Infections (STI)	
<input type="checkbox"/> Questions about Alcohol/Drugs	
<input type="checkbox"/> Thoughts of ending your life	
<input type="checkbox"/> Inability to walk away from fights	
<input type="checkbox"/> Relationship with parents/family	
<input type="checkbox"/> Sexual Problems (orgasms, erections, etc)	
<input type="checkbox"/> Other	

Immunization History – Check those that apply		
Hepatitis A	<input type="checkbox"/> #1 <input type="checkbox"/> #2	<input type="checkbox"/> Unknown
Hepatitis B	<input type="checkbox"/> #1 <input type="checkbox"/> #2 <input type="checkbox"/> #3	<input type="checkbox"/> Unknown
HPV	<input type="checkbox"/> #1 <input type="checkbox"/> #2 <input type="checkbox"/> #3	<input type="checkbox"/> Unknown
MMR	<input type="checkbox"/> #1 <input type="checkbox"/> #2	<input type="checkbox"/> Unknown
Meningitis	<input type="checkbox"/> #1 <input type="checkbox"/> #2	<input type="checkbox"/> Unknown
TB skin test	<input type="checkbox"/> #1	<input type="checkbox"/> Unknown
Tetanus	<input type="checkbox"/> within the last 10 years	<input type="checkbox"/> Unknown
Other		<input type="checkbox"/> Unknown

Sexual Health History – Check ALL items that apply	Sexual Health History – Check ALL items that apply - Review Date
Birth Sex <input type="checkbox"/> Female <input type="checkbox"/> Male	<input type="checkbox"/> No Changes since _____ I have reviewed the items. <input type="checkbox"/> No Changes since _____ I have reviewed the items.
Gender Identity <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender <input type="checkbox"/> Other _____	
<input type="checkbox"/> <u>Ever</u> had sexual intercourse?	
<input type="checkbox"/> Currently sexually active?	
<input type="checkbox"/> Use birth control? If yes, type: _____	
<input type="checkbox"/> Need birth control info?	
Partners are: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Both <input type="checkbox"/> Other _____	
Number of partners in the last: 3 months _____ 6 months _____ 12 months _____	
<input type="checkbox"/> Has someone ever been sexual with you in a way that made you uncomfortable or was without your permission/consent?	
<input type="checkbox"/> Interested in having children in the future	
Female Anatomy History (if applicable) (obstetric and gynecologic info)	
Age of first period _____	
Date of last menstrual period (LMP) _____	
How often have periods _____	
<input type="checkbox"/> Periods are regular?	
<input type="checkbox"/> Have severe menstrual cramps?	
<input type="checkbox"/> Other questions about periods?	
<input type="checkbox"/> Ever been pregnant? Number of times _____ Outcome? _____	
<input type="checkbox"/> Ever had a Pap? Date of last Pap _____	
<input type="checkbox"/> Had an abnormal Pap?	
<input type="checkbox"/> Had an abnormal Colposcopy?	
<input type="checkbox"/> Had an abnormal biopsy?	
Male Anatomy History (if applicable)	
<input type="checkbox"/> Noticed any lumps in testicles?	
<input type="checkbox"/> Perform self-testicular exam?	

Health Habits & Risks – Check ALL items that apply	Health Habits & Risks - Review
<input type="checkbox"/> <u>Ever</u> smoked a cigarette?	<input type="checkbox"/> No Changes since _____ I have reviewed the items. <input type="checkbox"/> No Changes since _____ I have reviewed the items.
If you smoke now, How much do you smoke? _____ How long have you smoked? _____ <input type="checkbox"/> Children in the house when you smoke?	
<input type="checkbox"/> You use chewing tobacco or snuff	
<input type="checkbox"/> You are interested in quitting tobacco use?	
How often do you have a drink containing alcohol? <input type="checkbox"/> 0 = never <input type="checkbox"/> 1 = monthly or less <input type="checkbox"/> 2 = two to four times a <i>month</i> <input type="checkbox"/> 3 = two to three times a <i>week</i> <input type="checkbox"/> 4 = four or more times a <i>week</i>	
How many standard drinks containing alcohol did you have on a typical day when you were drinking, in the <i>past month</i> ? <input type="checkbox"/> 0 – 2 <input type="checkbox"/> 3 – 4 <input type="checkbox"/> 5 – 6 <input type="checkbox"/> 7 – 9 <input type="checkbox"/> 10 +	
How often in the <i>past month</i> have you had 6 or more drinks in a day? <input type="checkbox"/> 0 = never <input type="checkbox"/> 1 = monthly or less <input type="checkbox"/> 2 = two to four times a <i>month</i> <input type="checkbox"/> 3 = two to three times a <i>week</i> <input type="checkbox"/> 4 = four or more times a <i>week</i>	
If you have quit drinking: Please indicate the month & year _____	
Ever Used for Recreation? Check ALL that apply.	
<input type="checkbox"/> Marijuana	
<input type="checkbox"/> Amphetamines (crystal meth, ice, crank or speed)	
<input type="checkbox"/> Barbiturates (downers, Quaaludes, sleeping pills)	
<input type="checkbox"/> Hallucinogens (PCP, LSD, mushrooms, ecstasy)	
<input type="checkbox"/> Cocaine (crack)	
<input type="checkbox"/> Inhalants (solvents, glue, gasoline, nitrous oxide)	
<input type="checkbox"/> Opiates (heroin, morphine, opium, codeine, vicodin)	
<input type="checkbox"/> Other drugs (tranquilizers, valium)	
<input type="checkbox"/> Taken painkillers, tranquilizers, or stimulants without a provider's orders	
<input type="checkbox"/> Taken a prescription drug over the prescribed dose (took more than you should)	
<input type="checkbox"/> Taken drugs intravenously (iv)	
If you have quit using: Please indicate the month & year _____	
<input type="checkbox"/> I have reviewed the info and no items apply to me	