

**STUDENT WELLNESS SERVICES**  
**Comprehensive Health Information Form**

Today's Date \_\_\_\_\_ (Fall Qtr.)  
 Today's Date \_\_\_\_\_ (Winter Qtr.)  
 Today's Date \_\_\_\_\_ (Spring Qtr.)

This document is a comprehensive overview of your health. Accurate and honest information helps the team give you personalized care & information about how to stay healthy. If you have any questions, please ask staff. Keep your responses brief and we will discuss your questions and concerns during your appointment. **All forms and records are kept strictly confidential.**

**Legal Name** \_\_\_\_\_ A# \_\_\_\_\_ Date of \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Last First MI Birth Month Day Year

**Name Used** \_\_\_\_\_ **Pronouns Used** \_\_\_\_\_

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:** \_\_\_\_\_  
 ( any herbs, vitamins, supplements, over the counter and prescribed medications including birth control, hormones )

**Personal Health History - Check ALL Past or Current**

- Allergies (foods) \_\_\_\_\_  
 (animals, latex, etc.) \_\_\_\_\_
- Asthma
- Alcoholism
- Blood Transfusion
- Cancer: (type) \_\_\_\_\_
- Chlamydia
- Diabetes
- Drug problem
- Eating Disorder / Concerns about Eating Disorder
- Gastrointestinal Disorder (circle): GERD IBS
- Genital Warts
- Gonorrhea: (when diagnosed/treated) \_\_\_\_\_
- Headache (circle): migraine / tension / chronic / severe
- Heart Disease
- Hepatitis (circle): Type A / Type B / Type C
- Herpes (circle): Genital / Oral
- Learning Disability (circle): ADD / ADHD / ASD
- Mental Health Diagnosis: (check all that apply):
  - Anxiety  Bipolar
  - Depression  Personality Disorder
  - Suicide Attempt  Schizophrenia
  - Mental Health Hospitalization
- Mononucleosis
- Pneumonia
- Positive TB Test
- Tetanus Immunization? When \_\_\_\_\_?
- Thyroid Condition
- Other, list here: (include operations, illnesses, etc.) \_\_\_\_\_

I have reviewed the info and **NO ITEMS** apply to me.

**Family Health History – Check ALL that apply**

- Adopted with no knowledge of biological health history
- Biological Mother Age: if living \_\_\_\_\_ if deceased \_\_\_\_\_
- Biological Father Age: if living \_\_\_\_\_ if deceased \_\_\_\_\_
- Number of Brothers \_\_\_\_\_
- Number of Sisters \_\_\_\_\_

**Please note which family member has had the following**  
 (ie: mother, father, paternal or maternal grandparents or siblings):

- Alcoholism (who: \_\_\_\_\_)
- Bleeding Disorders (who : \_\_\_\_\_)
- Cancer (type) (who : \_\_\_\_\_)
- Diabetes (who : \_\_\_\_\_)
- Drug Problem (who : \_\_\_\_\_)
- Heart Attack (before age 55) (who: \_\_\_\_\_)
- High Blood Pressure (who : \_\_\_\_\_)
- High Cholesterol (who : \_\_\_\_\_)
- Sickle Cell Anemia (who: \_\_\_\_\_)
- Stroke who: \_\_\_\_\_
- Thyroid Condition who: \_\_\_\_\_

Mental Health Diagnosis: (check & identify who)

- Anxiety who: \_\_\_\_\_
- Depression who: \_\_\_\_\_
- Bipolar (who: \_\_\_\_\_)
- Schizophrenia (who: \_\_\_\_\_)
- Suicide Attempt (who: \_\_\_\_\_)
- Suicide who: \_\_\_\_\_
- Mental Health Hospitalization (who: \_\_\_\_\_)

Other, list here: \_\_\_\_\_

I have reviewed the info and **NO ITEMS** apply to my family.

**GO TO THE NEXT PAGE PLEASE**

**FALL QTR**

**WINTER QTR**

**SPRING QTR**

General Health & Well-being	General Health & Well-being	General Health & Well-being
How would you describe your <b>general health</b> ?		
<input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	<input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	<input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
Over the <b>PAST TWO WEEKS</b> , 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	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	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
Over the <b>PAST TWO WEEKS</b> , have you been afraid you might:		
Hurt yourself?(circle) Yes No	Hurt yourself?(circle) Yes No	Hurt yourself?(circle) Yes No
Hurt someone else?(circle) Yes No	Hurt someone else?(circle) Yes No	Hurt someone else?(circle) Yes No
<b>Exercise</b> – Check those that apply		
<input type="checkbox"/> <b>Exercise</b> ?(circle) Yes No Type? _____ Times/week _____ For how long _____	<input type="checkbox"/> <b>Exercise</b> ?(circle) Yes No Type? _____ Times/week _____ For how long _____	<input type="checkbox"/> <b>Exercise</b> ?(circle) Yes No Type? _____ Times/week _____ For how long _____
<b>Electronic Devices</b> (internet, games, etc)		
Average hours per day _____ When? _____	Average hours per day _____ When? _____	Average hours per day _____ When? _____
<b>Safety</b> – Check those that apply		
<input type="checkbox"/> Working smoke detector at home <input type="checkbox"/> Fire extinguisher at home <input type="checkbox"/> Use motorcycle / bicycle helmet (circle which type or types used) <input type="checkbox"/> Own / have access to a firearm (circle which option is applicable)	<input type="checkbox"/> Working smoke detector at home <input type="checkbox"/> Fire extinguisher at home <input type="checkbox"/> Use motorcycle / bicycle helmet (circle which type or types used) <input type="checkbox"/> Own / have access to a firearm (circle which option is applicable)	<input type="checkbox"/> Working smoke detector at home <input type="checkbox"/> Fire extinguisher at home <input type="checkbox"/> Use motorcycle / bicycle helmet (circle which type or types used) <input type="checkbox"/> Own / have access to a firearm (circle which option is applicable)
<b>Diet</b> – Check those that apply		
<input type="checkbox"/> Usual diet _____ (omnivore, vegan, vegetarian, gluten-free, etc) <input type="checkbox"/> Caffeine intake (coffee, tea, mate, energy drinks) _____ Cups/day:	<input type="checkbox"/> Usual diet _____ (omnivore, vegan, vegetarian, gluten-free, etc) <input type="checkbox"/> Caffeine intake (coffee, tea, mate, energy drinks) _____ Cups/day:	<input type="checkbox"/> Usual diet _____ (omnivore, vegan, vegetarian, gluten-free, etc) <input type="checkbox"/> Caffeine intake (coffee, tea, mate, energy drinks) _____ Cups/day:

**GO TO THE NEXT PAGE PLEASE**

**FALL QTR**

**WINTER QTR**

**SPRING QTR**

**Social History** | **Social History** | **Social History**

**Ethnicity (optional)**

Do you identify as Hispanic / Latinx? Y / N

**Race (check all that apply) (optional)**

- Native American or Alaskan Native  Black and/or African American  White and/or Caucasian  Asian or Asian American  
 Native Hawaiian or Other Pacific Islander

Gender Identity: \_\_\_\_\_  
 (ie: female, genderqueer, male, trans\*...)

Gender Identity: \_\_\_\_\_  
 (ie: female, genderqueer, male, trans\*...)

Gender Identity: \_\_\_\_\_  
 (ie: female, genderqueer, male, trans\*...)

Are you:  
 Single  Partnered  Married  
 Divorced / Separated  
 Other \_\_\_\_\_

Are you:  
 Single  Partnered  Married  
 Divorced / Separated  
 Other \_\_\_\_\_

Are you:  
 Single  Partnered  Married  
 Divorced / Separated  
 Other \_\_\_\_\_

How long? \_\_\_\_\_  
 How satisfied in relationship/status? 1→10  
 (Unsatisfied) 1 2 3 4 5 6 7 8 9 10 (satisfied)

How long? \_\_\_\_\_  
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 (Unsatisfied) 1 2 3 4 5 6 7 8 9 10 (satisfied)

How long? \_\_\_\_\_  
 How satisfied in relationship/status? 1→10  
 (Unsatisfied) 1 2 3 4 5 6 7 8 9 10 (satisfied)

Feel safe in current relationship? Yes No

Feel safe in current relationship? Yes No

Feel safe in current relationship? Yes No

Current Work: \_\_\_\_\_

Current Work: \_\_\_\_\_

Current Work: \_\_\_\_\_

Hobbies:

Hobbies:

Hobbies:

Spiritual/Religious Practice:

Spiritual/Religious Practice:

Spiritual/Religious Practice:

**Check and Circle if any of the following are of concern:**

- Weight Gain / Loss / Body Shape
- Difficulty Concentrating / Distractable
- Very shy / Social Withdrawal
- Constant Worry / Can't Turn Mind Off
- Peer Pressure
- Nightmares
- Questions on Use: Alcohol / Drugs
- Sleeping: too much / too little
- Emotional Outbursts / Rage
- Fears / Phobias / Obsessions
- Sexual Concern (orgasms, erections, etc)
- Other

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- Fears / Phobias / Obsessions
- Sexual Concern (orgasms, erections, etc)
- Other

**Who You Live With:**

Name	Relationship	Age	Housemate? Y/N	Deceased? Y/N	Supportive? Y/N	Problems/Concerns

**GO TO THE NEXT PAGE PLEASE**

**FALL QTR**

**WINTER QTR**

**SPRING QTR**

Sexual Health History	Sexual Health History	Sexual Health History
Assigned at birth as: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Intersex <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? <input type="checkbox"/> Questions about STIs? <input type="checkbox"/> Interested in having children in the future?	Assigned at birth as: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Intersex <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? <input type="checkbox"/> Questions about STIs? <input type="checkbox"/> Interested in having children in the future?	Assigned at birth as: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Intersex <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? <input type="checkbox"/> Questions about STIs? <input type="checkbox"/> Interested in having children in the future?
Partners are (check all that apply): <input type="checkbox"/> Female <input type="checkbox"/> Genderqueer <input type="checkbox"/> Male <input type="checkbox"/> Trans* <input type="checkbox"/> _____ 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?	Partners are (check all that apply): <input type="checkbox"/> Female <input type="checkbox"/> Genderqueer <input type="checkbox"/> Male <input type="checkbox"/> Trans* <input type="checkbox"/> _____ 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?	Partners are (check all that apply): <input type="checkbox"/> Female <input type="checkbox"/> Genderqueer <input type="checkbox"/> Male <input type="checkbox"/> Trans* <input type="checkbox"/> _____ 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?
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?	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?	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"/> Noticed any lumps in testicles?	<input type="checkbox"/> Noticed any lumps in testicles?

**GO TO THE NEXT PAGE PLEASE**

**FALL QTR**

**WINTER QTR**

**SPRING QTR**

Health Habits & Risks	Health Habits & Risks	Health Habits & Risks
<input type="checkbox"/> <u>Ever</u> smoked a cigarette or vaped? If you smoke now, How much do you smoke/vape? _____ How long have you smoked? _____ <input type="checkbox"/> Use chewing tobacco or snuff? <input type="checkbox"/> Interested in quitting tobacco use?	<input type="checkbox"/> <u>Ever</u> smoked a cigarette or vaped? If you smoke now, How much do you smoke/vape? _____ How long have you smoked? _____ <input type="checkbox"/> Use chewing tobacco or snuff? <input type="checkbox"/> Interested in quitting tobacco use?	<input type="checkbox"/> <u>Ever</u> smoked a cigarette or vaped? If you smoke now, How much do you smoke/vape? _____ How long have you smoked? _____ <input type="checkbox"/> Use chewing tobacco or snuff? <input type="checkbox"/> Interested in quitting tobacco use?
How often do you use marijuana? <input type="checkbox"/> 0 = never <input type="checkbox"/> 1= monthly or less <input type="checkbox"/> 2 = two to three times a <i>week</i> <input type="checkbox"/> 3 = one or more times a <i>day</i>  How do you use marijuana? (smoke, eat, dab, etc)	How often do you use marijuana? <input type="checkbox"/> 0 = never <input type="checkbox"/> 1= monthly or less <input type="checkbox"/> 2 = two to three times a <i>week</i> <input type="checkbox"/> 3 = one or more times a <i>day</i>  How do you use marijuana? (smoke, eat, dab, etc)	How often do you use marijuana? <input type="checkbox"/> 0 = never <input type="checkbox"/> 1= monthly or less <input type="checkbox"/> 2 = two to three times a <i>week</i> <input type="checkbox"/> 3 = one or more times a <i>day</i>  How do you use marijuana? (smoke, eat, dab, etc)
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 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 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>	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>	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>
How often in the <i>past month</i> has drinking impacted everyday life? <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 often in the <i>past month</i> has drinking impacted everyday life? <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 often in the <i>past month</i> has drinking impacted everyday life? <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 <b>quit drinking</b> , please indicate the month & year: _____	If you have <b>quit drinking</b> , please indicate the month & year: _____	If you have <b>quit drinking</b> , please indicate the month & year: _____

**GO TO THE NEXT PAGE PLEASE**

**FALL QTR**

**WINTER QTR**

**SPRING QTR**

**Ever Used in the PAST? Check ALL that apply.**

- Hallucinogens (shrooms, ecstasy)
- Inhalants (solvents, glue, nitrous)
- Opiates (oxy, codeine, heroin)
- Stimulants (meth, Adderal, cocaine)
- Tranquilizers (benzos, Ambien)
- Taken painkillers, tranquilizers, or stimulants without a prescription?
- Taken a prescription drug more than the amount prescribed?
- Taken drugs intravenously (iv)
- Been in drug Treatment?
- Quit Using? When? \_\_\_\_\_

**I have reviewed the info and no items apply to me**

- Hallucinogens (shrooms, ecstasy)
- Inhalants (solvents, glue, nitrous)
- Opiates (oxy, codeine, heroin)
- Stimulants (meth, Adderal, cocaine)
- Tranquilizers (benzos, Ambien)
- Taken painkillers, tranquilizers, or stimulants without a prescription?
- Taken a prescription drug more than the amount prescribed?
- Taken drugs intravenously (iv)
- Been in drug Treatment?
- Quit Using? When? \_\_\_\_\_

**I have reviewed the info and no items apply to me**

- Hallucinogens (shrooms, ecstasy)
- Inhalants (solvents, glue, nitrous)
- Opiates (oxy, codeine, heroin)
- Stimulants (meth, Adderal, cocaine)
- Tranquilizers (benzos, Ambien)
- Taken painkillers, tranquilizers, or stimulants without a prescription?
- Taken a prescription drug more than the amount prescribed?
- Taken drugs intravenously (iv)
- Been in drug Treatment?
- Quit Using? When? \_\_\_\_\_

**I have reviewed the info and no items apply to me**

**CURRENTLY USING? Check ALL that apply.**

- Hallucinogens (shrooms, ecstasy)
- Inhalants (solvents, glue, nitrous)
- Opiates (oxy, codeine, heroin)
- Stimulants (meth, Adderal, cocaine)
- Tranquilizers (benzos, Ambien)
- Taken painkillers, tranquilizers, or stimulants without a prescription?
- Taken a prescription drug more than you should the amount prescribed?
- Taken drugs intravenously (iv)
- Been in drug Treatment?
- Quit Using? When? \_\_\_\_\_

**I have reviewed the info and no items apply to me**

- Hallucinogens (shrooms, ecstasy)
- Inhalants (solvents, glue, nitrous)
- Opiates (oxy, codeine, heroin)
- Stimulants (meth, Adderal, cocaine)
- Tranquilizers (benzos, Ambien)
- Taken painkillers, tranquilizers, or stimulants without a prescription?
- Taken a prescription drug more than you should the amount prescribed?
- Taken drugs intravenously (iv)
- Been in drug Treatment?
- Quit Using? When? \_\_\_\_\_

**I have reviewed the info and no items apply to me**

- Hallucinogens (shrooms, ecstasy)
- Inhalants (solvents, glue, nitrous)
- Opiates (oxy, codeine, heroin)
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- Tranquilizers (benzos, Ambien)
- Taken painkillers, tranquilizers, or stimulants without a prescription?
- Taken a prescription drug more than you should the amount prescribed?
- Taken drugs intravenously (iv)
- Been in drug Treatment?
- Quit Using? When? \_\_\_\_\_

**I have reviewed the info and no items apply to me**

Are there any items you wish to share that we have not asked about?

Are there any items you wish to share that we have not asked about?

Are there any items you wish to share that we have not asked about?

Thank you for taking the time to answer these important health related questions. We look forward to helping you make informed choices about your health care needs.