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 the 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.

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FALL QTR	WINTER QTR	SPRING QTR
General Health & Well-being	**General Health & Well-being**	**General Health & Well-being**
How would you describe your **general health**?		
☐ Excellent ☐ Good ☐ Fair ☐ Poor	☐ Excellent ☐ Good ☐ Fair ☐ Poor	☐ Excellent ☐ Good ☐ Fair ☐ Poor
Over the **PAST TWO WEEKS**, how often have you been bothered by:		
Little interest or pleasure in doing things. ☐ 0 – not at all ☐ 1= several days ☐ 2 = more than half the days ☐ 3 = nearly every day Feeling down, depressed or hopeless. ☐ 0 – not at all ☐ 1= several days ☐ 2 = more than half the days ☐ 3 = nearly every day	Little interest or pleasure in doing things. ☐ 0 – not at all ☐ 1= several days ☐ 2 = more than half the days ☐ 3 = nearly every day Feeling down, depressed or hopeless. ☐ 0 – not at all ☐ 1= several days ☐ 2 = more than half the days ☐ 3 = nearly every day	Little interest or pleasure in doing things. ☐ 0 – not at all ☐ 1= several days ☐ 2 = more than half the days ☐ 3 = nearly every day Feeling down, depressed or hopeless. ☐ 0 – not at all ☐ 1= several days ☐ 2 = more than half the days ☐ 3 = nearly every day
Over the **PAST TWO WEEKS**, have you been afraid you might:		
Hurt yourself?(circle) Yes No Hurt someone else?(circle) Yes No	Hurt yourself?(circle) Yes No Hurt someone else?(circle) Yes No	Hurt yourself?(circle) Yes No Hurt someone else?(circle) Yes No
Exercise – Check those that apply		
☐ **Exercise**?(circle) Yes No Type?_____ Times/week _____ For how long _____	☐ **Exercise**?(circle) Yes No Type?_____ Times/week _____ For how long _____	☐ **Exercise**?(circle) Yes No Type?_____ Times/week _____ For how long _____
Electronic Devices (internet, games, etc)	**Electronic Devices** (internet, games, etc)	**Electronic Devices** (internet, games, etc)
Average hours per day_____ When? _____	Average hours per day_____ When? _____	Average hours per day_____ When? _____
Safety – Check those that apply		
☐ Working smoke detector at home ☐ Fire extinguisher at home ☐ Use motorcycle / bicycle helmet (circle which type or types used) ☐ Own / have access to a firearm (circle which option is applicable)	☐ Working smoke detector at home ☐ Fire extinguisher at home ☐ Use motorcycle / bicycle helmet (circle which type or types used) ☐ Own / have access to a firearm (circle which option is applicable)	☐ Working smoke detector at home ☐ Fire extinguisher at home ☐ Use motorcycle / bicycle helmet (circle which type or types used) ☐ Own / have access to a firearm (circle which option is applicable)
Diet – Check those that apply		
☐ Usual diet _____ (omnivore, vegan, vegetarian, gluten-free, etc) ☐ Caffeine intake (coffee, tea, mate, energy drinks) _____ Cups/day:	☐ Usual diet _____ (omnivore, vegan, vegetarian, gluten-free, etc) ☐ Caffeine intake (coffee, tea, mate, energy drinks) _____ Cups/day:	☐ Usual diet _____ (omnivore, vegan, vegetarian, gluten-free, etc) ☐ Caffeine intake (coffee, tea, mate, energy drinks) _____ Cups/day:

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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, non-binary, male, trans…)	Gender Identity: _____ (ie: female, non-binary, male, trans…)	Gender Identity: _____ (ie: female, non-binary, male, trans…)
Are you: ☐ Single ☐ Partnered ☐ Married ☐ Divorced / Separated ☐ Other _____ How long? _____ Satisfied in relationships/status? 1→10 (Unsatisfied) 1 2 3 4 5 6 7 8 9 10 (satisfied) Feel safe in relationship(s)? Yes No Current Work:_____ Hobbies: Spiritual/Religious Practice:	Are you: ☐ Single ☐ Partnered ☐ Married ☐ Divorced / Separated ☐ Other _____ How long? _____ Satisfied in relationships/status? 1→10 (Unsatisfied) 1 2 3 4 5 6 7 8 9 10 (satisfied) Feel safe in relationship(s)? Yes No Current Work:_____ Hobbies: Spiritual/Religious Practice:	Are you: ☐ Single ☐ Partnered ☐ Married ☐ Divorced / Separated ☐ Other _____ How long? _____ Satisfied in relationships/status? 1→10 (Unsatisfied) 1 2 3 4 5 6 7 8 9 10 (satisfied) Feel safe in relationship(s)? Yes No Current Work:_____ Hobbies: 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	☐ 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	☐ 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

Who You Live With:

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

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FALL QTR	WINTER QTR	SPRING QTR
Sexual Health History	**Sexual Health History**	**Sexual Health History**
Assigned at birth as: ☐ Female ☐ Male ☐ Intersex		
☐ *Ever* had sexual intercourse? ☐ Currently sexually active? ☐ Use birth control? If yes, type:_____ ☐ Need birth control info? ☐ Questions about STIs? ☐ Interested in having children in the future?	☐ *Ever* had sexual intercourse? ☐ Currently sexually active? ☐ Use birth control? If yes, type:_____ ☐ Need birth control info? ☐ Questions about STIs? ☐ Interested in having children in the future?	☐ *Ever* had sexual intercourse? ☐ Currently sexually active? ☐ Use birth control? If yes, type:_____ ☐ Need birth control info? ☐ Questions about STIs? ☐ Interested in having children in the future?
Partners are (check all that apply): ☐ Female ☐ Non-binary ☐ Male ☐ Trans ☐ _____ Number of partners in the last: 3 months _____ 6 months _____ 12 months _____ ☐ 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): ☐ Female ☐ Non-binary ☐ Male ☐ Trans ☐ _____ Number of partners in the last: 3 months _____ 6 months _____ 12 months _____ ☐ 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): ☐ Female ☐ Non-binary ☐ Male ☐ Trans ☐ _____ Number of partners in the last: 3 months _____ 6 months _____ 12 months _____ ☐ 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 _____ ☐ Periods are regular? ☐ Have severe menstrual cramps? ☐ Other questions about periods? ☐ Ever been pregnant? Number of times _____ Outcome? _____ ☐ Ever had a Pap? Date of last Pap _____ ☐ Had an abnormal Pap? ☐ Had an abnormal Colposcopy? ☐ Had an abnormal biopsy?	Age of first period _____ Date of last menstrual period (LMP) _____ How often have periods _____ ☐ Periods are regular? ☐ Have severe menstrual cramps? ☐ Other questions about periods? ☐ Ever been pregnant? Number of times _____ Outcome? _____ ☐ Ever had a Pap? Date of last Pap _____ ☐ Had an abnormal Pap? ☐ Had an abnormal Colposcopy? ☐ Had an abnormal biopsy?	Age of first period _____ Date of last menstrual period (LMP) _____ How often have periods _____ ☐ Periods are regular? ☐ Have severe menstrual cramps? ☐ Other questions about periods? ☐ Ever been pregnant? Number of times _____ Outcome? _____ ☐ Ever had a Pap? Date of last Pap _____ ☐ Had an abnormal Pap? ☐ Had an abnormal Colposcopy? ☐ Had an abnormal biopsy?
Male Anatomy History (if applicable)		
☐ Noticed any lumps in testicles?	☐ Noticed any lumps in testicles?	☐ Noticed any lumps in testicles?

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FALL QTR	WINTER QTR	SPRING QTR
Health Habits & Risks	**Health Habits & Risks**	**Health Habits & Risks**
☐ *Ever* smoked a cigarette or vaped? If you smoke now, How much do you smoke/vape? _____ How long have you smoked?_____ ☐ Use chewing tobacco or snuff? ☐ Interested in quitting tobacco use?	☐ *Ever* smoked a cigarette or vaped? If you smoke now, How much do you smoke/vape? _____ How long have you smoked?_____ ☐ Use chewing tobacco or snuff? ☐ Interested in quitting tobacco use?	☐ *Ever* smoked a cigarette or vaped? If you smoke now, How much do you smoke/vape? _____ How long have you smoked?_____ ☐ Use chewing tobacco or snuff? ☐ Interested in quitting tobacco use?
How often do you use marijuana? ☐ 0 = never ☐ 1= monthly or less ☐ 2 = two to three times a *week* ☐ 3 = one or more times a *day* How do you use marijuana? (smoke, eat, dab, etc)	How often do you use marijuana? ☐ 0 = never ☐ 1= monthly or less ☐ 2 = two to three times a *week* ☐ 3 = one or more times a *day* How do you use marijuana? (smoke, eat, dab, etc)	How often do you use marijuana? ☐ 0 = never ☐ 1= monthly or less ☐ 2 = two to three times a *week* ☐ 3 = one or more times a *day* How do you use marijuana? (smoke, eat, dab, etc)
How often do you have a drink containing alcohol? ☐ 0 = never ☐ 1= monthly or less ☐ 2 = two to four times a *month* ☐ 3 = two to three times a *week* ☐ 4 = four or more times a *week* How many standard drinks containing alcohol did you have on a typical day when you were drinking, in the *past month*? ☐ 0 – 2 ☐ 3 – 4 ☐ 5 – 6 ☐ 7 – 9 ☐ 10 + How often in the *past month* have you had 6 or more drinks in a day? ☐ 0 = never ☐ 1= monthly or less ☐ 2 = two to four times a *month* ☐ 3 = two to three times a *week* ☐ 4 = four or more times a *week* How often in the *past month* has drinking impacted everyday life? ☐ 0 = never ☐ 1= monthly or less ☐ 2 = two to four times a *month* ☐ 3 = two to three times a *week* ☐ 4 = four or more times a *week*	How often do you have a drink containing alcohol? ☐ 0 = never ☐ 1= monthly or less ☐ 2 = two to four times a *month* ☐ 3 = two to three times a *week* ☐ 4 = four or more times a *week* How many standard drinks containing alcohol did you have on a typical day when you were drinking, in the *past month*? ☐ 0 – 2 ☐ 3 – 4 ☐ 5 – 6 ☐ 7 – 9 ☐ 10 + How often in the *past month* have you had 6 or more drinks in a day? ☐ 0 = never ☐ 1= monthly or less ☐ 2 = two to four times a *month* ☐ 3 = two to three times a *week* ☐ 4 = four or more times a *week* How often in the *past month* has drinking impacted everyday life? ☐ 0 = never ☐ 1= monthly or less ☐ 2 = two to four times a *month* ☐ 3 = two to three times a *week* ☐ 4 = four or more times a *week*	How often do you have a drink containing alcohol? ☐ 0 = never ☐ 1= monthly or less ☐ 2 = two to four times a *month* ☐ 3 = two to three times a *week* ☐ 4 = four or more times a *week* How many standard drinks containing alcohol did you have on a typical day when you were drinking, in the *past month*? ☐ 0 – 2 ☐ 3 – 4 ☐ 5 – 6 ☐ 7 – 9 ☐ 10 + How often in the *past month* have you had 6 or more drinks in a day? ☐ 0 = never ☐ 1= monthly or less ☐ 2 = two to four times a *month* ☐ 3 = two to three times a *week* ☐ 4 = four or more times a *week* How often in the *past month* has drinking impacted everyday life? ☐ 0 = never ☐ 1= monthly or less ☐ 2 = two to four times a *month* ☐ 3 = two to three times a *week* ☐ 4 = four or more times a *week*
If you have **quit drinking,** please indicate the month & year: _____	If you have **quit drinking,** please indicate the month & year: _____	If you have **quit drinking,** please indicate the month & year: _____

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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) ☐ 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**
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.