**Student Health Services**
5500 Campanile Drive
San Diego, CA 92182-4701
TEL: 619-594-4325
FAX: 619-594-3638
http://shs.sdsu.edu

SAN DIEGO STATE UNIVERSITY

**ATTACH PATIENT LABEL HERE**

# *CONFIDENTIAL HEALTH HISTORY*

## MEDICAL HISTORY

| YES | NO | |
|---|---|---|
| ☐ | ☐ | Frequent severe headaches or migraines: |
| ☐ | ☐ | Brain or nerve disorders/seizures: |
| ☐ | ☐ | Vision or hearing problems (except glasses): |
| ☐ | ☐ | Ear, nose or throat problems: |
| ☐ | ☐ | Chronic or recurrent skin disease: |
| ☐ | ☐ | Hives or anaphylaxis: |
| ☐ | ☐ | Asthma or lung disease: |
| ☐ | ☐ | Stomach or intestinal problems: |
| ☐ | ☐ | Liver or gallbladder disease/hepatitis: |
| ☐ | ☐ | Kidney or bladder disease: |
| ☐ | ☐ | Gynecologic problems: |
| ☐ | ☐ | Back or joint problems/arthritis: |
| ☐ | ☐ | HIV or other cause of immune system suppression: |
| ☐ | ☐ | Hospitalization or surgery: |

| | | | **Parents or siblings** |
|---|---|---|---|
| ☐ | ☐ | Mental health problem(s) including eating disorder: | ☐ |
| ☐ | ☐ | Alcohol or drug abuse: | ☐ |
| ☐ | ☐ | Heart disease, high cholesterol or high blood pressure: | ☐ |
| ☐ | ☐ | Stroke | ☐ |
| ☐ | ☐ | Blood clot in leg or lungs: | ☐ |
| ☐ | ☐ | Anemia or other blood disorder/sickle cell/thalassemia: | ☐ |
| ☐ | ☐ | Cancer/leukemia/lymphoma: | ☐ |
| ☐ | ☐ | Diabetes: ☐ Type 1 ☐ Type 2 | ☐ |

Other/List:

☐ I do not know the medical history of my parents or siblings.

## DEMOGRAPHIC INFORMATION

Legal Name: _____ Red ID: _____ Birthdate: _____
(Last / First / MI)

Birth Sex: ☐ Male ☐ Female ☐ Intersex Gender Identity: _____ Preferred Name/Pronouns: _____

Current Address: _____

Phone Number: _____ Email address: _____

## EMERGENCY CONTACT

Name: _____ Cell phone number: _____ Relationship: _____

## PLEASE READ AND SIGN

I affirm that I have filled out this form to the best of my knowledge. I understand that it is important to inform my healthcare provider if the information changes.

_____ _____ _____
(Signature of Patient) (Red ID) (Date)