CSUDH
CALIFORNIA STATE UNIVERSITY, DOMINGUEZ HILLS

NAME
I.D. #
D.O.B.

STUDENT HEALTH CENTER

COMPREHENSIVE HEALTH HISTORY

(310) 243-3629
(310) 217-6990 (Fax)

✐Please complete the information on this form. All information is **CONFIDENTIAL** and will not be released unless you grant permission or as required by law.

PERSONAL HISTORY: (✓Check all that apply)

❑Insomnia
❑Sinus trouble
❑Dizziness
❑Eye, ear, nose, throat trouble
❑Severe headaches
❑Stroke
❑Seizure disorder
❑Thyroid disease
❑Neck Problems
❑Blood clots in veins or lungs
❑Chronic cough
❑Back problems
❑Breast lump or tumor
❑Nipple discharge
❑Heart disease or chest pain
❑High blood pressure
❑Bronchitis/Influenza
❑Sickle cell disease
❑Anemia
❑Liver disease
❑Gall bladder disease
❑Diabetes
❑Hepatitis or jaundice
❑Weight gain or loss
❑Cancer__________
Type
❑Bladder or kidney infections
❑Infection in tubes/uterus (PID)
❑Tubal (ectopic) pregnancy
❑Vaginal infections
❑Recurrent diarrhea
❑Ovarian tumors or cysts
❑Rectal bleeding/irritation
❑Other:______________

Please list: Allergies____ Current Medications:____

FAMILY HISTORY (Give relationship if your parents, grandparents, brothers and/or sisters have had any of the following):

Relationship		Relationship		Relationship	
_________________	Cancer	_______________	Sickle cell anemia	____________	Pregnancy complications
_________________	Tuberculosis	_______________	Blood disorders		
_________________	Heart Attacks	_______________	Drug allergies	_____________	Other
_________________	Heart Disease	_______________	Epilepsy		
_________________	Stroke	_______________	Diabetes		
_________________	Hypertension	_______________	Glaucoma		

EMOTIONAL HEALTH

YES	NO	
❑	❑	Self-esteem issues
❑	❑	Anxiety/Excessive Nervousness/Stress
❑	❑	Other:_______________
❑	❑	Interested in psychological counseling?

SUBSTANCE USE

Amount **Frequency**

Alcohol____________________________________
Smoking___________________________________
Inject. Steroids______________________________
Other Drugs(specify):_________________________
____

HEALTH PROMOTION (✓Check the appropriate box)

YES	NO	
❑	❑	Do you exercise 3 or more times a week for 20 or more minutes?
❑	❑	Have you had your cholesterol checked?
❑	❑	Do you have any questions regarding nutrition?
❑	❑	Do you have any concerns about your genitalia (i.e., sores, discharge, dysfunction, etc.)
❑	❑	Do you do monthly breast exams?
❑	❑	(**Females)** Have you ever had a mammogram?
❑	❑	**(Males)** Do you do monthly testicular exams?

IMMUNIZATION HISTORY

Date(s)

Tetanus___________________
MMR_____________________
Flu Vaccine________________
Hepatitis B________________
TB Screening_______________

(Please continue on reverse side)

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Primary Care Provider 's Use Only → ***Review/Comments:***

SEXUAL HISTORY

YES	NO	
❑	❑	Have you ever had intercourse? If yes, age at first intercourse:_____
❑	❑	Do you have any discomfort or pain during intercourse?
❑	❑	Have you had unprotected intercourse in the past six months?
❑	❑	Have you ever had a sexually transmitted disease? **(✓Check all that apply)**

❑ Genital warts ❑Herpes ❑ Chlamydia ❑ Other:_____
❑ Syphilis ❑HIV/AIDS ❑ Gonorrhea

❑	❑	Do you have any concerns about sex or your sexuality?

FEMALE HEALTH HISTORY: (**Females only**)

YES	NO	**PREVIOUS EXAMS**
❑	❑	Have you had a gynecologic (pelvic) exam or Pap smear before?

If yes, where?_____ when?_____
Results: ❑ Normal ❑ Abnormal Explain (If abnormal):_____

❑	❑	Have you ever attended the Educational Session on Family Planning? If yes, _____ Date

MENSTRUAL HISTORY
Age menstruation (period) began: _____years.
How many days between your menstrual periods? _____

❑	❑	Do you soak more than 5 pads/tampons a day?
❑	❑	Have your menstrual cycles been frequently irregular?

If yes, what is the longest time you have gone between periods? _____

		Are you troubled by:	**YES**	**NO**	
❑	❑	Bleeding between periods or after intercourse	❑	❑	Depression/Anxiety
❑	❑	Mid-cycle pains	❑	❑	Breast tenderness/fullness
❑	❑	Vaginal discharge, itching, irritation or sores	❑	❑	Weight gain more than 5 lbs.
❑	❑	Burning with urination	❑	❑	Ankle swelling
❑	❑	Severe cramping	❑	❑	Headache

YES	NO	**PREGNANCY HISTORY**
❑	❑	Have you ever been pregnant?

Total number of pregnancies_____
Number of miscarriages_____Which year(s)_____
Number of live births_____Which year(s)_____
Number of abortions_____Which year(s)_____

CONTRACEPTIVE HISTORY: Please indicate which of these contraceptive methods you have used.
❑ "Pill" ❑ Condoms ❑ Diaphragm/Cervical Cap ❑ IUD ❑ Withdrawal
❑ Sponge ❑ Rhythm method ❑ Norplant ❑ Spermicidal ❑ Other:_____

What is your current birth control method?_____

❑	❑	Are you satisfied with your current method?

If no, what method would you like to use?_____

❑	❑	Have you had any problems or pregnancies while using any birth control method?

If yes, which method(s)?_____

Students' Name (Please print)_____

Student's Signature_____**Date**_____

Parent or Guardian's Signature (If student is under age 18)_____**Date**_____

Primary Care Provider 's Use Only → ***Review/Comments:***

PCP Signature_____Date_____