UCSF Student Health & Counseling Services **Medical History Form**

Date: _____ Name: _____ Date of Birth: _____ Age: _____

Reason for Visit:	**Are there any issues or problems you would like to discuss today?**
❑ Exam with Pap ❑ Exam without Pap ❑ Repeat pap (<12 months) ❑ Complete Physical	

Health Care Maintenance: **(Please list dates)**

Last Dental Exam: _____/_____/_____ or Never

Last eye exam: _____/_____/_____ or Never

Last tetanus: _____/_____/_____ or Never

Last Physical Exam: _____/_____/_____ or Never

Last PAP smear: _____/_____/_____ or Never

Medical History:

Provide approximate dates if you ever have had:

Migraine Headaches	_____	Ear Problems	_____
Thyroid Disorder	_____	Heart Trouble	_____
Heart Disease	_____	Recurrent Anxiety or Depression	_____
High Blood Pressure	_____	Problems sleeping	_____
Blood clots or Phlebitis	_____	Tooth or gum problems	_____
Anemia or Blood Disorder	_____	Weight or appetite changes	_____
Breast Problems	_____	Suicidal thoughts	_____
Hepatitis or Liver Disease	_____	Asthma or hay fever	_____
Gastrointestinal Disorder	_____	Seasonal allergies or hay fever	_____
Diabetes	_____	Allergy to food, animal, insects	_____
Cancer	_____	Endometriosis	_____
Urinary Tract Infection	_____	Pelvic Inflammatory Disease	_____

Current Medications: π none (list)_____

Medication Allergies: π none (list)_____

Current Major Medical Problems: π none (list)_____

Surgeries: π none (list dates)_____

Age you began menstruating	_____
First day of last period	_____/_____/____
How often do you menstruate?	π monthly π other _____
History of Abnormal Pap?	π yes π no
Pregnancy History:	π **Never been pregnant** **#_____ Term deliveries** **#_____ Miscarriages** **#_____ Ectopic** **#_____ Abortion**
How many paps have you had since becoming sexually active in the last five years?	_____
Current contraception method	π none π condom π BC Pill π Nuva Ring π IUD π diaphragm π rhythm

Health Habits and Maintenance

Do you smoke?	π yes π no how much _____
Alcohol (beer, wine, liquor)	_____ glasses/week
Do you ever use recreational drugs?	π yes π no
How many times per week do you exercise?	_____ times/week
Caffeine (coffee, tea, soda)	_____ cups/day
Do you worry about eating or your weight?	π yes π no
Do you wear your seatbelt?	π yes π no
Do you have a smoke alarm where you live?	π yes π no
Do you wear a bike/motorcycle helmet?	π yes π no π do not bicycle
Have you been hit/kicked or threatened in the past 6 months?	π yes π no
Have you hit/kicked or threatened someone else in the past 6 months?	π yes π no
Do you have a gun in your home?	π yes π no

Social History:
- ❑ Single
- ❑ Married
- ❑ Significant Other
- ❑ Divorced
- ❑ Widowed
- ❑ Children
- ❑ Domestic Partner

School:
- ❑ Medicine
- ❑ Dental
- ❑ Pharmacy
- ❑ Graduate Academic
- ❑ Nursing
- ❑ Scholars & Researchers HP
- ❑ Physical Therapy
- ❑ Dependent

Family History: List any major medical conditions present in your parents, siblings, or grandparents. Check all that apply:

- π Elevated Cholesterol
- π Diabetes Mellitus
- π Hypertension
- π Strokes
- π Heart Attacks
- π Cancer _____
- π Other _____

Ever had sex?	π yes π no
Sex with men?	π yes π no
Sex with women?	π yes π no
Currently sexually active?	π yes π no
How long with current partner?	_____ yrs _____months
Currently, do you have more than one partner?	π yes π no
Currently, does your partner have more than one partner?	π yes π no
Have you had more than 1 sexual partner in your life?	π yes π no
Ever tested for STD?	π yes π no
Any history of STDs?	π none π chlamydia π gonorrhea π herpes π genital warts π HPV π trichomoniasis π syphilis π other _____