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?**
❑ 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

Medical History:

Provide approximate dates if you ever have had:

Migraine Headaches _____
Thyroid Disorder _____
Heart Disease _____
High Blood Pressure _____
Blood clots or Phlebitis _____
Anemia or Blood Disorder _____
Breast Enlargement / Lumps _____
Hepatitis or Liver Disease _____
Gastrointestinal Disorder _____
Diabetes _____
Cancer _____
Urinary Tract Infection _____

Ear Problems _____
Heart Trouble _____
Recurrent Anxiety or Depression _____
Problems sleeping _____
Tooth or gum problems _____
Weight or appetite changes _____
Suicidal thoughts _____
Asthma _____
Seasonal allergies or hay fever _____
Allergy to food, animal, insects _____

Current Medications: π none (list)_____

Medication Allergies: π none (list)_____

Current Major Medical Problems: π none (list)_____

Surgeries: π none (list dates)_____

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 do monthly testicular exams?	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 _____