Health History Form

Student Health and Counseling Services, California State University, East Bay, Hayward, California 94542-3060 (510) 885-3735

Last First Middle	
Name:	**Birth Date:** ❒ Minor
Street City State Zip	
Address:	
Gender: M ❒ F ❒ Transgender ❒ Transfluid ❒ Other ❒ _____	Netid:
Home Phone: ( ) Cell Phone: ( )	
Authorized to leave medical message? Home Phone: ❒ Yes ❒ No Cell Phone: ❒ Yes ❒ No	

Person To Be Notified In Case Of Emergency:

Name:		
Address:	Phone : ( )	Relationship:

Personal Physician:

Name:	
Address:	Phone : ( )
Health Plan/Insurance Policies (List Names/Policy No.):	

Personal Health History: (*continue on reverse side if needed*)

1. List major or ongoing medical problems; give dates first diagnosed (e.g., asthma, hay fever):
2. List major operations, prolonged illness, injuries, hospitalizations; give dates:
3. List *Allergies* to medications: (Please describe type of reaction):
4. List current medications and dosages (write "none" if not on medication):
5. List Family Medical History (e.g., high blood pressure, diabetes):

	Yes	No
▪ Do you smoke?		
▪ Alcohol: Did you have 5 or more drinks in one sitting during the last 30 days?		
▪ Are you concerned about becoming pregnant or getting your partner pregnant?		
▪ Have you felt down or depressed, excessively anxious or nervous during the last 30 days?		
▪ Do you wear seatbelts every time you are in a car, including the back seat?		

In the case of illness and/or injury, permission is granted to treat the above named individual at California State University, East Bay, and to make referrals to outside physicians and facilities, if indicated. I consent that Student Health and Counseling Services staff may consult with each other as needed to benefit my care.

_____ _____ _____ _____

Patient's Signature | Date | Parent/Guardian's Signature (Required for all minor students.) | Date

The information contained herein is confidential and for use by the Student Health and Counseling Services for the purpose of providing medical care, health information, information about Student Health and Counseling Services or in the case of an emergency. Please return your completed form to the Student Health and Counseling Center. Thank you!

FOR CLINIC USE ONLY:	**Date:**
Discussed ❒ Handouts ❒ Referred ❒	**Provider Signature:**