Reset Print

DE ANZA COLLEGE STUDENT HEALTH SERVICES
ANNUAL HEALTH HISTORY QUESTIONNAIRE

Name: _____ **Date of Birth:** _____ **Student ID#:** _____

Past Medical History: Please mark the following as it applies to you or family members.

Illness	Self	Family		Illness	Self	Family		Illness	Self	Family
ADHD	☐	☐		Diabetes	☐	☐		HIV+ / immune disorder	☐	☐
Alcohol or Drug problems	☐	☐		Eating Disorders	☐	☐		Liver problems	☐	☐
Anemia	☐	☐		Epilepsy or seizures	☐	☐		Lung disease	☐	☐
Anxiety	☐	☐		Family Violence	☐	☐		Migraine or Chronic headaches	☐	☐
Asthma	☐	☐		Genital tumor or problem	☐	☐		Sexually Transmitted Infections	☐	☐
Bladder/kidney problems	☐	☐		Head injury / concussion	☐	☐		Skin disorder	☐	☐
Blood disorders	☐	☐		Heart disease / heart murmur	☐	☐		Stomach/ GI problems	☐	☐
Breast tumor/problem	☐	☐		Hepatitis (indicate type)	☐	☐		Suicide Attempt	☐	☐
Cancer (indicate type)	☐	☐		Hypertension (high blood pressure)	☐	☐		Thyroid problems	☐	☐
Depression / Suicide	☐	☐		High cholesterol	☐	☐		Tuberculosis / PPD positive	☐	☐

Check each item below and describe any "Yes" answers to the space given:	YES	NO	Describe "Yes" answers below:
1. Do you have any **allergies** (medications, food, etc)?	☐	☐	
2. Are you currently taking any medications (over-the-counter, prescription)?	☐	☐	
3. Are you currently under the care of a physician?	☐	☐	
4. Have you been hospitalized or have history of hospitalization / surgeries?	☐	☐	
5. Have you ever had thoughts of killing yourself?	☐	☐	
6. Do you currently have a plan to kill yourself?	☐	☐	
7. Have you ever felt threatened, controlled by, or afraid of a partner, family member, or caregiver?	☐	☐	
8. Has anyone touched the sexual parts of your body in a way you didn't like or without your permission?	☐	☐	

PERSONAL HISTORY:

What sex were you assigned at birth? ☐ Male ☐ Female

What pronouns do you prefer? ☐ He/His ☐ She/Her

What is your gender identity? _____

How many sexual partners have you had in your life? _____

Were they: ☐ Male / ☐ Female / ☐ Both

Are you currently having sex? ☐ Yes ☐ No

Are you at risk for pregnancy? ☐ Yes ☐ No

Have you been screened for STI's? ☐ Yes ☐ No

Female History Only:

Age of onset of period: _____ Menopause: ☐ Yes ☐ No

Date of last menstrual period: _____

Date of last pap smear / WWE: _____

Result: _____

Are your periods regular? ☐ Yes ☐ No

Number of pregnancies: _____ Number of live birth: _____

Method of birth control: _____

SOCIAL HISTORY:

Current occupation: _____

Relationship status: _____

Do you drink alcohol? ☐ Yes ☐ No

If Yes, indicate type and frequency: _____

Do you use tobacco (including e-cig)? ☐ Yes ☐ No

If Yes, indicate type and frequency: _____

Do you use recreational drug? ☐ Yes ☐ No

If Yes, indicate type and frequency: _____

IMMUNIZATION HISTORY:

Have you received these vaccines (mark all that apply)?

☐ Flu ☐ Tdap ☐ Varicella (Chickenpox)

☐ Hep A ☐ Meningococcal ☐ HPV

☐ Hep B ☐ MMR

Please sign one line only

Patient Signature:	Date:	Clinician Signature:	Date:
Patient Signature:	Date:	Clinician Signature:	Date:
Patient Signature:	Date:	Clinician Signature:	Date: