San Diego City College
Student Health Clinic

MEDICAL HISTORY FORM

Student ID#:_____

Name: _____Date of Birth: _____
Last First MI

ALLERGIES: **Yes ( ) No ( )** If yes, please list all allergies: _____

_____

CURRENT MEDICATIONS: Yes ( ) No ( ) If yes, please list all medications including over-the-counter medications, herbs, or supplements: _____

_____

HOSPTIALIZATIONS: Yes ( ) No ( ) If hospitalized overnight, please list reason and dates: _____

_____

SURGERIES: **Yes ( ) No ( )** If yes, please list all surgeries and dates: _____

HAVE YOU HAD PROBLEMS WITH ANY OF THE FOLLOWING?

CONDITION	Yes	No	CONDITION	Yes	No
Allergies or "hay fever"			Kidney (disease/infections/stones)		
Anemia			Migraine headaches		
Arthritis or joint problems			Pap smear abnormal		
Asthma			Seizure(s)		
Autoimmune disorder			Sexually Transmitted Infections		
Back problems or injury			Skin (MRSA or other problems)		
Bladder infection/UTI			Thyroid		
Bleeding disorder			Tuberculosis		
Blood clots			Traumatic Brain Injury		
Cancer			Ulcer		
Concussion			Pregnancy # Live Births #		
COPD			Mental Health:		
Diabetes			• Anxiety		
Heart Disease			• Depression		
Heart Murmur			• Eating Disorder		
Heavy and/or painful periods			• PTSD		
Hepatitis			• Bipolar		
High blood pressure			Other conditions:		
High cholesterol					
HIV or AIDS					
Intestinal problems					

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FAMILY HISTORY: **Circle** if any of the following are present in family members & specify which family members:

◆ Cancer:_____ ◆ Heart Disease:_____ ◆ Stroke:_____

◆ Diabetes:_____ ◆ High Blood Pressure:_____ ◆ Mental Illness:_____

◆ Autoimmune Disorder:_____ ◆ Thyroid Disease:_____

Other_____

LIFESTYLE REVIEW

	Yes	No	Amount
Alcohol			Drinks per day: Per week:
Tobacco			Packs per day: Years of smoking: Quit date:
Drugs			Describe:
Marijuana			Describe:
Previous Substance Use			Describe:
Caffeine			Amount:
Exercise			Type and frequency:

IMMUNIZATION REVIEW

Date of last Tetanus shot: _____Are your other immunizations up to date? Yes ( ) No ( ) Unsure ( )

MISCELLANEOUS

	Yes	No		Yes	No
Are you under the care of another medical provider or mental health professional?			Glasses or contact lenses		
Hearing aid or hearing difficulties			Physical challenge or disability		
Speech difficulty			Learning difficulty		

Any other pertinent information not included above:_____

_____

_____

_____

_____

_____

Patient Signature (or signature of Parent/Guardian if under 18 years of age) Date

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