Chabot-Las Positas Student Health Center
Affiliated with Valley Care Health System

New Patient Confidential Health History Questionnaire

Name_____ Date of Birth _____ Today's Date ___/___/___

PLEASE ANSWER TO THE BEST OF YOUR ABILITY. INCLUDE ANYTHING FROM CHILDHOOD TO THE PRESENT. CHECK AND INDICATE DATE OF OCCURANCE.

SURGERY

- ❑ Tonsils
- ❑ Hernia
- ❑ Colon
- ❑ Hysterectomy
- ❑ Uterus
- ❑ Prostate
- ❑ Thyroid
- ❑ Appendix
- ❑ Gall Bladder
- ❑ Breast
- ❑ Vasectomy or Tubal Ligation
- ❑ Cataract
- ❑ In hospital overnight for any other illness or injury
- ❑ Other _____
- ❑ **Check if none**

MAJOR ILLNESSES

- ❑ Pneumonia/Lung
- ❑ Stroke
- ❑ Diabetes
- ❑ Ulcer
- ❑ Heart Attack
- ❑ Hepatitis
- ❑ Asthma
- ❑ Eating Disorder
- ❑ Mononucleosis
- ❑ Tuberculosis
- ❑ High Blood Pressure
- ❑ Depression
- ❑ Anxiety disorder
- ❑ Skin disorder
- ❑ **MRSA** infections or Antibiotic resistant infection
- ❑ **G6PD deficiency**
- ❑ Other _____
- ❑ **Check if none**

FAMILY HISTORY

Check and indicate only for parents, brothers, sisters, and grandparents

- ❑ Cancer
- ❑ Heart Attack
- ❑ Stroke
- ❑ Glaucoma
- ❑ Diabetes
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Tuberculosis
- ❑ Thyroid disease
- ❑ Alcoholism
- ❑ Suicide
- ❑ Depression
- ❑ Mental illness
- ❑ Family Violence
- ❑ Other _____
- ❑ **Check if None**

SOCIAL HISTORY

- ❑ Coffee ____Cups/Day
- ❑ Exercise Hours/Week _____hours
- ❑ Sleep Deprived?
- ❑ Alcohol
  ___Social
  ___Daily
  ___None
- ❑ Tobacco/Smoking
  ___Pack/Day
  ___Year/Month
  ___Former ___Never
- ❑ Illicit Drugs
  ___Yes___No
- ❑ Stress Level
  ___low
  ___moderate
  ___high
- ❑ Other _____

MAJOR INJURY

- ❑ Back
- ❑ Concussion
- ❑ Broken Bones
- ❑ Other_____
- ❑ **Check if none**

ALLERGIES

- ❑ Food _____ _____
- ❑ Medications _____ _____
- ❑ **None**

VACCINES

- ❑ Tetanus ___**Year**
- ❑ TB Test ___**Year**
  ___Negative
  ___Positive
- ❑ MMR ___ **Year**
- ❑ Varicella ___**Year**
- ❑ Meningitis ___**Year**
- ❑ Hepatitis:
  A___**Year**
  B ___**Year**

MEDICATIONS

List any current medications you are taking:
(Include routine OTC, herbal and supplements non-prescription drugs)

_____

_____

_____

FOR FEMALES ONLY

(For Non- Well Woman Visit)

- ❑ Date of last menstrual period _____
- ❑ Method of Birth Control _____
- ❑ Any Pregnancies? Yes___ No____
  If Yes, how many? _____ Live Birth? _____
- ❑ Have you ever had a Pap smear test?
  Yes _____ No_____
- ❑ Date of last pap? Month____ Year____
  Normal or Abnormal
- ❑ Have you ever had an abnormal pap smear?
  Yes_____ No____
  If yes, what date? _____
- ❑ Do you do self breast exams? Yes___ No___
- ❑ Mammogram screening?
  If Yes, what date? _____

REASON FOR TODAY'S VISIT

OFFICE USE ONLY

Initials if updated: _____/_____/_____

Date: _____/_____/_____