HEALTH QUESTIONNAIRE CONFIDENTIAL INFORMATION

Saddleback College Student Health Services

Name:	Student ID:	Staff ID:	Community Member:
Date:	Date of Birth:	Male Female	Allergies:
Current Phone:	Emergency Contact Name:	Emergency Contact Number:	
Can we leave a message? Yes No	Medical Doctor Name:	Medical Doctor Number:	Chief Complaint:

Please check all recent or active medical problems:

SKIN ☐N/A
- ☐ Dryness
- ☐ Itching
- ☐ Rash
- ☐ Eczema
- ☐ Psoriasis
- ☐ Wound

HEAD ☐N/A
- ☐ Sinusitis
- ☐ Stuffy Nose/Bleed
- ☐ Itchy Eyes
- ☐ Head Injury/Concussion
- ☐ Ear Pain
- ☐ Headaches
- ☐ Seizures

HEART ☐N/A
- ☐ Chest Pain
- ☐ Shortness of Breath
- ☐ Heart Murmur
- ☐ Swelling Legs
- ☐ Palpitations

DIGESTIVE ☐N/A
- ☐ Diarrhea
- ☐ Constipation
- ☐ Cramping
- ☐ Rectal Bleeding
- ☐ Abdominal Pain
- ☐ Liver Problems
- ☐ GI Reflux

SEXAL HISTORY
- ☐ Sexually Active
- ☐ Sexual Problems

HISTORY OF: ☐N/A
- ☐ Chlamydia
- ☐ Herpes
- ☐ Warts
- ☐ Other _____

RESPIRATORY ☐N/A
- ☐ Wheezing
- ☐ Coughing
- ☐ Coughing Blood
- ☐ Sputum Daily
- ☐ Asthma
- ☐ Shortness of Breath

URINARY ☐N/A
- ☐ Frequency
- ☐ Burning
- ☐ Frequent Infection
- ☐ Urinating at Night
- ☐ Blood in Urine
- ☐ Discharge

MUSCLE/BONE ☐N/A
- ☐ Pain
- ☐ Low Back Pain
- ☐ Neck Pain
- ☐ Difficulty Walking
- ☐ Arthritis
- ☐ Numbness
- ☐ Weakness

SENSORY ORGANS ☐N/A
- ☐ Hearing Problems
- ☐ Vision Problems
- ☐ Dizziness
- ☐ Glasses

ENDROCRINE ☐N/A
- ☐ Thyroid Disease
- ☐ Diabetes
- ☐ Other Endocrine Problems

MOOD DISORDERS ☐N/A
- ☐ Anxiety
- ☐ Sleeping Problems
- ☐ Stress
- ☐ Family Problems
- ☐ Marital Problems
- ☐ Depression

NUTRITION
- ☐ Weight loss (unexplained)
- ☐ Weight Gain
- ☐ Special Diet

PAST MEDICAL HISTORY OR OTHER DISEASES
- ☐ Heart Disease
- ☐ Thyroid Problem
- ☐ High Cholesterol
- ☐ Arthritis
- ☐ Lupus
- ☐ Osteoporosis
- ☐ Gout
- ☐ Cataracts
- ☐ Fractures
- ☐ Birth Defects
- ☐ Liver Problems
- ☐ Headaches
- ☐ Drug/Alcohol Use (in recovery)
- ☐ IV Drug Use (past/current)
- ☐ Unprotected Sex (past/current)
- ☐ Diabetes since age: _____
- ☐ Stroke
- ☐ Cancer of: _____

CHILDHOOD ILLNESS
- ☐ Measles
- ☐ Tuberculosis
- ☐ Chicken Pox
- ☐ Mumps
- ☐ Rheumatic Fever

FEMALES ONLY

Last Pap (date)_____
Last mammogram_____
Last period_____
Age first period_____
Number of pregnancies_____
Number of live births_____
Current method of birth control:
Birth control pills ☐yes ☐no
Injections ☐yes ☐no
IUD ☐ yes ☐no
Condoms ☐ yes ☐no
Do you need education on birth control? ☐ yes ☐no

Family History – List Illnesses and/or Cause of Death

Father: _____ Brothers: _____ Sons: _____
Mother:_____ Sisters: _____ Daughters: _____

Your Surgeries or Hospitalizations:	**Year:**

Current or Past Medications:

Smoking: ☐ **None** ☐ **Cigarettes** ☐ **Vape** ☐ **Hookah** ☐ **Marijuana**
How much? _____

Do you wear a seatbelt every time you ride in a car? (Yes / No)

Do you exercise regularly? (Yes / No)

Would you like to receive health education information? If so, on what subject?

_____
_____
_____

Please check concerns you would like to address:

☐ Feeling aggressive, angry or violent	☐ Sexual orientation/gender identity concerns
☐ Frequent arguments, losing your temper	☐ Sexual performance concerns
☐ Thoughts of hurting someone else	☐ Feeling guilty about sexual activities
☐ Fear of losing control	☐ Recurrent, persistent intrusive thoughts
☐ Feeling down, depressed, unhappy	☐ Difficulty controlling thoughts or actions
☐ Being lonely and/or isolated	☐ Concern about alcohol or drug use
☐ Thinking about suicide	☐ Low self-esteem/self confidence
☐ Recent death or loss of someone	☐ Legal concerns
☐ Problems with impulsivity	☐ Repetitive bothersome behaviors
☐ Frequent mood swings/instability	☐ Break-up of a relationship
☐ Feeling disoriented or feeling suspicious	☐ Parenting concerns
☐ Seeing or hearing things others do not see or hear	☐ Financial concerns
☐ Excessive time online/internet/gaming	☐ Problems at school
☐ History of sexual abuse, assault or trauma	☐ Concern about grades/academic performance
☐ History of bullying/being bullied	☐ Problems at work/employment/unemployment
☐ Concerns about childhood abuse	☐ Concerns about housing
☐ History of conflicted relationships	☐ Concerns about eating
☐ Difficulty expressing emotions	☐ Concerns related to immigration or citizenship
☐ Feeling nervous in social settings	☐ Religious or spiritual concerns
☐ Other concerns (Please describe):	

Are you a:
☐ First Generation college student ☐ DSPS student ☐ Veteran/Service Member ☐ EOPS Student ☐ International Student

Are you a survivor of violence or other trauma? (Yes / No) Date of incident(s): _____

Are you receiving accommodations from DSPS? (Yes / No)

Do you have a current Therapist/Psychologist? (Yes / No)
Name and Phone #

Do you have a current Psychiatrist? (Yes / No)
Name and Phone #:

☐ **If none apply at this time, please check this box. Thank you.**