HEALTH QUESTIONNAIRE CONFIDENTIAL INFORMATION

Saddleback College Student Health Services

Name: Last: First:	Student ID:	Staff ID:	Community Member:
Date:	Date of Birth:	Male Female Non-Binary	**Allergies:**
Current Phone:	Emergency Contact Name:	Emergency Contact Number:	
Can we leave a message? Yes No	Chief Complaint:		

Please check all that apply or check N/A next to the area *if it does not apply:*

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

SEXUAL 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

GYN HEALTH ☐N/A

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 Any Serious 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?
_____
_____
_____
Do you have a current Psychologist/Psychiatrist? (Yes / No)
Name & Phone:

Are you a: ☐ **First Generation College Student** ☐ **DSPS Student** ☐ **EOPS Student** ☐ **Veteran/Service Member** ☐ **International Student**

PHQ-9

Over the last 2 weeks, how often have you been bothered by the following problems?

		0	+1	+2	+3
1.	Little interest or pleasure in doing things	___	___	___	___
2.	Feeling down, depressed or hopeless	___	___	___	___
3.	Trouble falling asleep, staying asleep, or sleeping too much	___	___	___	___
4.	Feeling tired or having little energy	___	___	___	___
5.	Poor appetite or overeating	___	___	___	___
6.	Feeling bad about yourself-or that you're a failure or have let yourself or your family down	___	___	___	___
7.	Trouble concentrating on things, such as reading the newspaper or watching television	___	___	___	___
8.	Moving or speaking so slowly that other people could have noticed. Or, opposite-being so fidgety or restless that you have been moving around a lot more than usual	___	___	___	___
9.	Thoughts that you would be better off dead or of hurting yourself in some way	___	___	___	___
	Total Score	___	___	___	___

GAD-7

		Not at All sure	Several Days	Over half the days	Nearly every day
1.	Feeling nervous, anxious, or on edge	0	1	2	3
2.	Not being able to stop or control worrying	0	1	2	3
3.	Worrying too much about different things	0	1	2	3
4.	Trouble relaxing	0	1	2	3
5.	Being so restless that it's hard to sit still	0	1	2	3
6.	Becoming easily annoyed or irritable	0	1	2	3
7.	Feeling afraid as if something awful might happen	0	1	2	3
	Add the score for each column	0+	+	+	+
	Total Score (add your column scores) =	_____			

*****If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? **Not difficult at all _____; Somewhat difficult _____; Very Difficult _____; Extremely difficult _____;**

CAGE-AID

When thinking about drug use, include illegal drug use and the use of prescription drug use other than prescribed.

1. Have you ever felt that you ought to cut down on your drinking or drug use? **Yes / No**
2. Have people annoyed you by criticizing your drinking or drug use? **Yes / No**
3. Have you ever felt bad or guilty about your drinking or drug use? **Yes / No**
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? **Yes / No**

Please check concerns you would like to address: **If none apply at this time, please check this box.** ☐

☐ Feeling aggressive, angry or violent	☐ Sexual orientation/gender identity concerns	☐ Difficulty expressing emotions
☐ Frequent arguments, losing your temper	☐ Sexual performance concerns	☐ Difficulty controlling thoughts or actions
☐ Thoughts of hurting someone else	☐ Feeling guilty about sexual activities	☐ Concerns about housing
☐ Being lonely and/or isolated	☐ History of sexual abuse, assault or trauma	☐ Financial concerns
☐ Problems with impulsivity	☐ History of bullying/being bullied	☐ Legal concerns
☐ Recent death or loss of someone	☐ Concerns about child abuse	☐ Immigration/citizenship concerns
☐ Frequent mood swings/instability	☐ Feeling disoriented or feeling suspicious	☐ Parenting concerns
☐ Seeing/hearing things others do not see/hear	☐ Excessive time online/internet/gaming	☐ Other concerns