# 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

**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

**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.**