USC Engemann
Student Health Center
Keck Medicine of USC

Place Patient Label Here

Health History Form

Please provide to the best of your knowledge, complete and accurate information about your health history, medications (including over-the-counter products and dietary supplements), allergies or sensitivities.

Section 1. Patient Information

Legal Name (Last, First):	**Preferred Name:**	**USC ID # :**
Today's Date (MM/DD/YY):	**Date of Birth** (MM/DD/YY):	**Cell Phone** (Include area code):

Section 2. Allergies (list all)

	Allergy	Type of reaction		Allergy	Type of reaction
1.			**4.**		
2.			**5.**		
3.			**6.**		

Section 3. Current Prescribed Medications

(List all prescribed medications, including topicals, inhalers and contraceptives.)

	Medication	Dosage, if known		Medication	Dosage, if known
1.			**4.**		
2.			**5.**		
3.			**6.**		

Section 4. Current Herbal/Vitamins or Non-Prescribed Medications

	Medication	Dosage, if known		Medication	Dosage, if known
1.			**4.**		
2.			**5.**		
3.			**6.**		

Section 5. Illness or Injuries

1.	**3.**	**5.**
2.	**4.**	**6.**

Section 6. Surgeries

	Year	Reason		Year	Reason
1.			**4.**		
2.			**5.**		
3.			**6.**		

Section 7. Family History

Have any close relatives (i.e. parents, siblings, grandparents...etc) ever had any of the following? Check all that apply

- ☐ Alcohol or substance abuse
- ☐ Depression/Psychiatric illness
- ☐ High Cholesterol
- ☐ Blood or clotting disorders
- ☐ Diabetes
- ☐ Heart Disease or Stroke < age 50
- ☐ Cancer
- ☐ High Blood Pressure
- ☐ Hereditary disease

List any close relatives who have died:

	Relationship	Age	Cause of Death
1.			
2.			
3.			

Section 8. Office Use Only

Reviewed By: **(Initial/Date)**

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Patient Information

Legal Name (Last, First)**:** **Preferred Name:** **Today's Date** (MM/DD/YY):

Question	Response
1. Do you have any questions or concerns regarding any of the following:	
Smoking Cessation	☐Yes ☐No
Alcoholism or Drug Abuse	☐Yes ☐No
Your appearance or weight	☐Yes ☐No
Rape, sexual abuse, or unwanted sexual activity	☐Yes ☐No
Physical Abuse	☐Yes ☐No
Dating or Domestic Violence	☐Yes ☐No
Death of a loved one within 12 months	☐Yes ☐No
Unplanned Pregnancy	☐Yes ☐No
Sleep problems or use of sleep medication	☐Yes ☐No
2. Have you felt sad, lonely or depressed for over two consecutive weeks?	☐Yes ☐No
3. Do you have any mental health condition?	☐Yes ☐No
4. Do you use tobacco products (cigarettes, chewing tobacco, hookah…etc.)	☐Yes ☐No
5. How many days per week do you drink alcohol?	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7
6. Do you ever have more than 3-4 alcoholic drinks a day?	☐Yes ☐No
7. Have you used any recreational drugs such as: ecstasy, narcotics, stimulants, cocaine, LSD, tranquilizers, or abuse prescription drugs?	☐Yes ☐No
8. Do you use marijuana?	☐Yes ☐No
9. Have you ever experienced any negative consequences or injuries as a result of alcohol or drugs?	☐Yes ☐No