USC Engemann Student Health Center

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

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

This information will not be released to anyone without your written consent. Answers to the following questions help your clinician provide appropriate care for you. Leave questions blank if you are uncomfortable answering them. Please feel free to discuss any concerns with your clinician.

Gynecologic Health (questions 1-8)

1. Do you have IRREGULAR periods?	☐Yes ☐No
2. Do you have significant problems with premenstrual syndrome (PMS)?	☐Yes ☐No
3. Has it been more than 1 year since your last PAP?	☐Yes ☐No
4. Have you had an abnormal PAP?	☐Yes ☐No
5. Have you ever been pregnant?	☐Yes ☐No
6. Do you have pain during periods that limit regular activity?	☐Yes ☐No
7. Do you have excessive bleeding with your periods?	☐Yes ☐No
8. Do you have bleeding between periods?	☐Yes ☐No

Sexual Health (questions 9-26)

9. Do you have any symptoms that concern you?	☐Yes ☐No
10. Have you ever been sexually active (i.e. any genital contact with another person)?	☐Yes ☐No
11. Have your sexual partners been:	☐Men ☐Women ☐Both
12. Do you have any concerns/questions regarding :	
Sexual functioning or orgasm?	☐Yes ☐No
Sexual orientation?	☐Yes ☐No
Gender identity?	☐Yes ☐No
Your own sexuality?	☐Yes ☐No
13. Have you ever had any of the following sexually transmitted diseases (STD's):	
Chlamydia	☐Yes ☐No
Gonorrhea	☐Yes ☐No
Genital warts / HPV	☐Yes ☐No
Herpes	☐Yes ☐No
HIV	☐Yes ☐No
14. Have you ever had unprotected sex?	☐Yes ☐No
15. Do you have questions regarding contraceptive methods?	☐Yes ☐No
16. Have you or your partner ever had an unplanned pregnancy?	☐Yes ☐No
17. Would you like information about emergency contraception?	☐Yes ☐No

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18. 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
19. Have you felt sad, lonely or depressed for over two consecutive weeks?	☐Yes ☐No
20. Do you have any mental health condition?	☐Yes ☐No
21. Do you use tobacco products (cigarettes, chewing tobacco, hookah)	☐Yes ☐No
22. How many days per week do you drink alcohol?	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7
23. Do you ever have more than 3-4 drinks a day?	☐Yes ☐No
24. Have you used any recreational drugs such as: ecstasy, narcotics, stimulants, cocaine, LSD, tranquilizers, or abuse prescription drugs?	☐Yes ☐No
25. Do you use marijuana?	☐Yes ☐No
26. Have you ever experienced any negative consequences or injuries as a result of alcohol or drugs?	☐Yes ☐No