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)**