ASU HEALTH SERVICES

HEALTH HISTORY

LAST NAME		EMERGENCY CONTACT NAME
FIRST NAME		RELATIONSHIP
ASU ID#	BIRTH DATE (Month/Date/Year)	CONTACT PHONE NUMBER

I AM AT ASU HEALTH SERVICES TODAY BECAUSE:

	PERSONAL MEDICAL HISTORY:	Date diagnosed (month-year)
	ABNORMAL PAP SMEAR	
	ACNE	
	ALLERGIES / HAY FEVER	
	ANEMIA	
	ANOREXIA/BULIMIA	
	ARTHRITIS	
	ASTHMA	
	BACK PROBLEMS	
	BLEEDING DISORDER	
	BLOOD CLOTS / PHLEBITIS	
	CANCER	
	CHOLESTEROL / TRIGLYCERIDE	
	CHRONIC KIDNEY CONDITION	
	COLITIS ULCERATIVE/CROHN'S	
	DEPRESSION	
	DIABETES MELLITUS	
	EPILEPSY / SEIZURES	
	HEADACHE- MIGRAINE	
	HEADACHE- TENSION	
	HIGH BLOOD PRESSURE	
	KIDNEY STONES	
	LIVER DISEASE	
	MONOUCLEOSIS	
	PREMENSTRUAL SYNDROME	
	THYROID PROBLEMS	
	OTHER MEDICAL ISSUES:	

	SURGERIES/OPERATIONS/INJURIES	month/year

	CURRENT MEDICATIONS-NAME, DOSE, HOW OFTEN

FAMILY MEDICAL HISTORY

☐ I am adopted - Unknown family medical history

Please fill out the info below

	Mom	Dad	Sister	Brother	Other Relative
Alive and Healthy/ No Problems					
No info/I don't know					
Alcoholism					
Allergies (Nasal)					
Anxiety					
Asthma					
Blood Clots/DVT					
Cancer					
Type-					
Cholesterol (high)					
Colitis					
Depression					
Diabetes					
Drug Problems					
Epilepsy/Seizures					
Heart Attack/MI					
High Blood Pressure					
Hyperthyroidism (high)					
Hypothyroidism (low)					
Kidney Disease					
Liver Disease					
Migraines					
Obesity					
Stroke					
Other Diseases					

ALLERGIES

Medications: Name of Medication	Reaction (rash, upset stomach)

IMMUNIZATIONS

(if known)	# of shots needed	Shot #1	Shot #2	Shot #3
Chicken Pox	1			
Gardisil (HPV)	3 (0, 2m, 6m)			
Hepatitis A	2 (0, 1m)			
Hepatitis B	3 (0, 1m, 6m)			
Twinrix Hep A&B	3			
Tetanus	every 10 years			
Meningitis	1			
Tb skin test PPD	at risk individuals			
Other-				

TURN PAGE OVER

Last Name, First Name

ASU ID#

Social History For care provider to determine health risk

Primary Language Spoken

- ☐ English
- ☐ Spanish
- ☐ other: _____

I live with:

- ☐ self (no roommate)
- ☐ roommates
- ☐ family members (spouse, parents, siblings)
- ☐ other _____

Sexual History

- ☐ No previous sexual history **(skip to next section)**
- ☐ Opposite Sex (male with female, female with male)
- ☐ Same Sex (male with male, female with female)
- ☐ Bisexual

# of current partners:_____

# of lifetime partners: _____

age at first intercourse: _____
(used for female PAP testing)

Hx of sexually transmitted infection (STI's)

- ☐ none
- ☐ yes

if yes _____

Use of condoms to protect against STI's

- ☐ Always
- ☐ Sometimes
- ☐ Never

Birth Control Method

- ☐ Abstinence
- ☐ Withdrawal
- ☐ Condoms
- ☐ Oral Contraceptive Pills
- ☐ IUD
- ☐ Other _____

Alcohol, Drug and Smoking Usage

Smoke Tobacco Cigarettes

- ☐ Never
- ☐ Formerly Quit (mos or yrs ago)_____
- ☐ Yes

circle one

< 1-2 cigarettes/day	1 pack per day
1/2 pack per day	>1 pack per day

- ☐ Other tobacco usage (chew, pipe etc)

Drug Use* confidential to be used by your health care provider to determine health risk.

- ☐ none
- ☐ yes- Please list _____
- ☐ formerly- date quit _____

Alcohol Use

- ☐ none
- ☐ yes How many do you drink? _____ drinks (12 oz beer, 5 oz wine, one mixed drink with 1 shot of liquor)

circle one

rarely	< once/week	2-3X/week
occasionally	once a week	daily

Do you usually drink more than 5 drinks at one time? Yes / No

- ☐ former use- date quit_____

Wellness Questions- Check box for all positive responses

- ☐ Are you so stressed that it interferes with schoolwork or job?
- ☐ Over the past two weeks, have you had little interest or pleasure in doing things more than 1/2 of the days?
- ☐ Over the past two weeks, have you felt down, depressed, or hopeless more than 1/2 of the days?
- ☐ Does someone makes you feel unsafe in your house (eg verbally, sexually or physically abused)?
- ☐ Are you currently considering hurting yourself or suicide?
- ☐ Are you currently considering hurting or killing someone else?
- ☐ Have you used laxatives or vomited to control your weight?
- ☐ Are you concerned that you need to lose weight?
- ☐ Do you want to see the dietician at CHS to go over a healthy diet?
- ☐ Do you use a tanning bed or sunbathe without use of sunscreen?

PATIENT SIGNATURE	Date

- ☐ Nursing Immediate referral to:_____
- ☐ Nursing staff member

____ performed PHQ-9 (see results)
____ referred patient to Dietician
____ Gave patient information on C&C services

- ☐ Patient reports to nursing staff member no concerns at this time

REVIEWING NURSING STAFF MEMBER SIGNATURE	Date

REVIEWING CLINICIAN SIGNATURE	Date