Student Health Services
5500 Campanile Drive
San Diego, CA 92182-4701
TEL: 619-594-4325
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http://shs.sdsu.edu

SDSU San Diego State University

ATTACH PATIENT LABEL HERE

ANNUAL HEALTH HISTORY

MEDICAL HISTORY

Do you have a history of (Check all that apply, if yes, please explain):

- ☐ Alcohol or drug abuse:
- ☐ Anemia:
- ☐ Asthma or lung disease:
- ☐ Autoimmune disease (rheumatoid arthritis, lupus, etc.):
- ☐ Back or joint problems/arthritis:
- ☐ Blood clot in leg or lungs:
- ☐ Brain or nerve disorders/seizures:
- ☐ Cancer/Leukemia/Lymphoma:
- ☐ Chronic or recurrent skin disease:
- ☐ Diabetes Type 1 or 2:
- ☐ Ear, Nose, or Throat problems:
- ☐ Frequent severe headaches or migraines:
- ☐ Gynecological problems such as abnormal bleeding:
- ☐ Heart disease such as high cholesterol or high blood pressure:
- ☐ Hives or anaphylaxis:
- ☐ Infections (HIV, Lyme disease, MRSA, Tuberculosis/TB etc.):
- ☐ Kidney or bladder disease:
- ☐ Liver or gallbladder disease/hepatitis:
- ☐ Mental health disorder:
- ☐ Other blood disorders (i.e. sickle cell, thalassemia etc.):
- ☐ Stomach or intestinal problems:
- ☐ Stroke:
- ☐ Thyroid/endocrine disease:
- ☐ Vision or hearing problems (except glasses):
- ☐ None of the above

Do you have allergies or reactions to medication, food, and/or environmental factors?

- ☐ Yes, please specify:
- ☐ No

Have you had any surgeries in the past?

- ☐ Yes, please list surgeries and dates:
- ☐ No

FAMILY HISTORY

Family History (check all that apply to your first degree relatives– biological parents, siblings, and grandparents– and explain):

- ☐ Heart disease such as high cholesterol or high blood pressure:
- ☐ Stroke:
- ☐ Blood Clot in leg or lungs:
- ☐ Anemia or other blood disorders:
- ☐ Back or joint problems/arthritis:
- ☐ Blood clot in leg or lungs:
- ☐ Cancer/Leukemia/Lymphoma:
- ☐ Infections (HIV, Lyme disease, MRSA, Tuberculosis/TB etc.):
- ☐ Diabetes Type 1 or 2:
- ☐ Mental health disorder:
- ☐ Alcohol or drug abuse:
- ☐ Other (please describe):
- ☐ None of the above
- ☐ I do not know the medical history of my family

DEMOGRAPHIC INFORMATION

Legal Name: _____ Preferred Name: _____
Last First MI

Preferred Pronoun: ☐ She, Her, Hers ☐ He, Him, His ☐ They, Them, Theirs ☐ Ze, Hir, Hirs ☐ Xe, Xem, Xyrs

☐ Other (please specify):_____

Preferred Language: ☐ English ☐ Chinese including Mandarin, Cantonese ☐ French ☐ German ☐ Italian

☐ Japanese ☐ Korean ☐ Russian ☐ Spanish ☐ Tagalog ☐ Vietnamese ☐ Other (please specify): _____

Red ID: _____ Birthdate: _____ Birth Sex: ☐ Male ☐Female ☐ Intersex

Current Address: _____

Phone Number: _____ Email address: _____

INSURANCE INFORMATION (IF APPLICABLE)

Please note that we do not bill insurance.

Name of Insurance Carrier: _____

Policy Holder's Name: _____

Member's Name: _____

Policy Number: _____

Group Number: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Phone Number: _____

Relationship: _____

PLEASE READ AND SIGN

I affirm that I have filled out this form to the best of my knowledge. I understand that it is important to inform my healthcare provider if the information changes.

_____ _____ _____
(Signature of Patient) (Red ID) (Date)