

**Dominican University of California
Student Health Center**

Medical History – To be completed by student

Name _____ Birth date _____ Age: _____ Date _____
Last First
Address _____
Street City Zip
Phone _____ Cell phone _____ email _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY

Name _____ Relationship _____
Phone _____ Cell _____ email _____

Recent Health Care Providers (past few years)

Provider's Name _____ City _____ Phone _____

Current Medical Insurance

Please complete the following:

Yes No

- Current, Chronic or Ongoing Medical Problems: If yes, describe: _____

- Serious birth, developmental or childhood illnesses? If yes, describe: _____

- Other Past Medical Problems: If yes, describe: _____

- Operations or severe injuries? If yes, describe: _____

- Medications taken regularly. If yes, specify: _____

- Allergies. If yes, specify: _____

Specific conditions- please check if have had problems in the past or present and describe if checked:

Yes No

- Neurologic problems (e.g., seizures, headaches) _____

- Psychological disorders (e.g., depression, eating disorder, bipolar, etc.) _____

- Substance abuse or alcoholism _____
- Endocrine disorders (e.g., diabetes, thyroid, etc.) _____
- Gastrointestinal disorders (e.g., irritable bowel, gallstones, liver disease) _____

- Cardiovascular disorders (e.g., high blood pressure, heart disease, venous or arterial disorders) _____

- Pulmonary disorders (e.g., asthma, TB, cystic fibrosis) _____

- Blood or immune disorders (e.g., bleeding, clotting disorders) _____
- Ear/nose/mouth/eyes/throat disorders (e.g., hearing or vision problems, ear infections, mono, strep, others) _____

- Dermatologic (e.g., severe acne, eczema, psoriasis, rashes) _____
- Urinary tract (e.g., kidney, bladder) _____
- Musculoskeletal (e.g., joint, back, muscle problems) _____
- Other not mentioned above _____
- For women- gynecological problems _____

Family History: Please list any significant medical problems in close family members. such as diabetes, cancer, heart disease, addiction or alcoholism, psychiatric illness, etc.

Issues or special needs of which you want us to be aware? _____

Completed by: _____ Date: _____