



DOMINICAN UNIVERSITY OF CALIFORNIA
Student Health Center

MEDICAL HISTORY – TO BE COMPLETED BY STUDENT

Name: _____ Birth date: _____ Age: _____ Date: _____
First Last MI

Address: _____

Phone: (____) - _____ - _____ Cell Phone: (____) - _____ - _____ Email: _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY

- Name: _____ Relationship: _____
Phone: _____ Cell Phone: _____

RECENT HEALTH CARE PROVIDER (past few years)

- Provider's Name: _____ City: _____ Phone: _____
Current Medical Insurance: _____

Please complete the following:

- | YES | NO | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Current, chronic or ongoing medical problems: If yes, describe: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Serious birth, developmental or childhood illnesses? If yes, describe: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Other past medical problems? If yes, describe: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Operations or severe injuries? If yes describe: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Medications taken regularly. If yes, describe: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Allergies. If yes, specify: _____ |

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

- | YES | NO | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Neurologic problems (e.g., seizures, headaches) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Psychological problems (e.g., depression, anxiety, eating disorders, bipolar, ADHD, _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Substance abuse or alcoholism _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Endocrine disorders (e.g., irritable bowel syndrome, gallstones, liver disease) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Cardiovascular disorders (e.g., high blood pressure, heart disease, venous/arterial disorders) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Pulmonary disorders (e.g., asthma, TB, cystic fibrosis) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood or immune disorders (e.g., bleeding, clotting disorders) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Ear/nose/throat/mouth/eyes disorders (e.g., hearing or vision problems, ear infections, mono, strep) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Dermatologic (e.g., severe acne, eczema, psoriasis, rashes) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Urinary tract (e.g., kidney, bladder) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Musculoskeletal (e.g., joint, back, muscle problems) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Other not mentioned above _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 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 that you want us to be aware of? _____

Completed by: _____ Date: _____