



University of California, Irvine  
STUDENT HEALTH CENTER

501 Student Health  
Irvine, CA 92697-5200  
(949) 824-5301  
www.shs.uci.edu

**CONFIDENTIAL**  
**PERSONAL HEALTH HISTORY**  
(To be completed by the student or patient)

Page 1.  
Complete legibly in black ink

Name \_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_\_\_ Student I.D. # \_\_\_\_\_  
Last First Middle  
Date of Birth \_\_\_\_\_ Place of Birth \_\_\_\_\_ Resident of U.S.A. \_\_\_\_\_ Ethnicity \_\_\_\_\_  
Mo Day Year No. of Years (Optional)

THE INFORMATION COMPLETED ON THIS FORM IS ACCURATE TO THE BEST OF MY KNOWLEDGE. I AM AWARE THAT INACCURACIES OR OMISSIONS MAY JEOPARDIZE MY HEALTH.

\_\_\_\_\_ Date \_\_\_\_\_ Signature of Student/Patient

Do you have a family doctor?  Yes  No

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State and Zip \_\_\_\_\_

Office Phone No. ( ) \_\_\_\_\_

**Student/Patient:**

Home Address \_\_\_\_\_

City \_\_\_\_\_ State and Zip \_\_\_\_\_

Phone No. ( ) \_\_\_\_\_

**Parent, legal guardian or spouse/partner:**

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State and Zip \_\_\_\_\_

Phone No. ( ) \_\_\_\_\_

**Whom to notify in case of emergency (other than above):**

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State and Zip \_\_\_\_\_

Phone No. ( ) \_\_\_\_\_

**Family Medical History**

Check diseases or conditions that are/were present in your family.

√	Conditions	Which Family Member(s)
	Heart disease, stroke, high blood pressure	
	Diabetes	
	Kidney disease	
	Liver disease	
	Asthma, hay fever, allergy	
	Epilepsy/convulsion	
	Cancer - specify:	
	Mental disorder - specify:	
	Others - explain:	

All undergraduate students are automatically enrolled in the Undergraduate Student Health Insurance Plan (USHIP). Students who are insured under a comparable health plan may waive out of USHIP by completing the on-line waiver form at [www.shs.uci.edu](http://www.shs.uci.edu). Waivers must be completed annually.

If waiving out, please indicate your insurance carrier:

Insurance Carrier: \_\_\_\_\_

Policy No.: \_\_\_\_\_

Subscriber No.: \_\_\_\_\_

**NOTE: Completing the information above does NOT constitute an insurance waiver. Please go to [www.shs.uci.edu](http://www.shs.uci.edu) for information on the waiver process.**

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Please attach recent photograph, of any size that will fit within this space. This is requested for your protection, to prevent the use of your medical record by others, a felonious act which may have disastrous results for all concerned, such as treatment errors.

In addition, this permanent record will reflect all SHC visits. It cannot be changed. You may someday request that we release information contained herein to an insurance company, employer, etc., and you may be jeopardizing your future by being unaware of the nature of such information.

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