Last Name First Name MI

PERSONAL HEALTH HISTORY *Complete legibly in black ink*

1. Allergies Yes ___ No ___

a. To which drugs ______________________________

b. To which environmental allergens ______________________________

2. Lifestyle

Check if you use the following.

√	Substance	Quantity/Frequency
	Tobacco	
	Alcohol	
	Caffeine	
	Nonprescription steroids	
	Recreational drugs - Specify:	
	Other:	

3. Medications - List all medications you take regularly, including over-the-counter drugs, health supplements and vitamins ______________________________

____

4. Check all the childhood illnesses that you have had. Check ___ if none.

	Chickenpox		Rubella (German measles)		Polio
	Mumps		Measles (Rubeola)		Infectious mono
	Diphtheria		Whooping cough		Rheumatic fever

5. Check all conditions below you currently have or have had. Check ___ if none.

√		√		√	
	Congenital or birth defects		Frequent abdominal pain		Convulsions or epilepsy
	Poor vision **not** corrected by glasses/contacts		Frequent indigestion/Heartburn		Narcolepsy
	Difficulty in hearing/Need hearing aid		Swallowing difficulty		Sleep disorder
	Frequent colds or respiratory infections		Ulcer disease		Frequent or chronic headaches
	Frequent or chronic sinus infection		Gall bladder disease		Diabetes mellitus
	Hay fever/Allergy		Liver disease including Hepatitis A, B, C		Thyroid disease or goiter
	Asthma		Pancreatitis		Hormonal disorder
	Recurrent or chronic bronchitis		Spastic colon		Benign tumor growth
	Pneumonia (what year)		Kidney disease or kidney stone		Cancer or malignancy
	Chronic lung disease		Frequent urinary tract infections		Unexplained weight loss
	Heart disease or heart murmur		Recurrent joint pain or swelling		Chronic fatigue
	High blood pressure		Arthritis		Tuberculosis
	Irregular heart beats		Neck or back problem		Sexually transmitted infections
	Frequent dizziness or fainting spells		Scoliosis		Eating disorder/Anorexia/Bulimia
	Anemia		Fracture		Mental health issue (you can choose to elaborate below)

6. Please give details on conditions checked above (year of onset, treatment received, condition resolved or current).

____

____

7. Are you under a health professional's care for conditions not listed above? Please give details (year of onset, treatment received, condition resolved or current).

____

____

8. Are there any other health concerns you have which may require additional support from campus resources?

____

____

9. STUDENT'S AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

In the event of a serious illness or accident, I give UCI-Student Health Center or its representative(s) permission to secure medical care by a physician or hospital of their choice for me, if such is deemed necessary for my health. I agree to pay all medical costs.

______________________ Signature ____________ Date

10. AUTHORIZATION FOR MEDICAL OR PSYCHOLOGICAL TREATMENT FOR MINOR (LESS THAN 18 YEARS OF AGE AT ENROLLMENT)

I, ______________________________ (print name), student's parent or legal guardian, hereby authorize any healthcare provider at UCI Student Health Center, to administer any medical treatment to him/her that is deemed necessary.

______________________ Signature ____________ Date