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HEALTH & WELLNESS SERVICES



Offered in partnership with Riverside Health System

NEW PATIENT HEALTH INFORMATION FORM

**If you are 18 years of age or older, your UHWS Medical Records will be kept for six (6) years or until you graduate beginning with your first visit in UHWS.

*If you are under 18, your records will be kept for six years beginning with your first visit after turning 18 years old.

Please be aware you have the right, at any time, to obtain further medical advice from a health professional of your choice including off campus options.

Please answer the following to the best of your ability: (PLEASE PRINT) _____/_____/_____ Date

Date of Birth: ____/____/____ SSN: ____-____-____ CNU ID# _____

Name: _____ Age: _____
LAST FIRST MIDDLE

Home Address: _____
STREET CITY STATE ZIP CODE

Home of Record Phone: _____ Cell: _____

Local Address/Residence Hall: _____ Box#: _____

Local Phone: _____ Preferred to be contacted by: Cell phone / email / home phone

Email Address: _____

Marital Status: (circle one) S / M / W / D / Sep Sex: (circle one) M / F / T

Race: (circle one) Asian / Hispanic / Caucasian / Black or African American / Native American / Chinese / Filipino / Japanese Native Hawaiian / Pacific Islander / Multiracial / Declined

Preferred Language Spoken: _____

Ethnicity: (circle one) Hispanic or Latino / Non-Hispanic or Latino / Other or Undetermined / Declined

Employment Status: (circle one) Student / (Fac-staff) Full-time / (Fac-staff) Part-Time

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IN CASE OF EMERGENCY, please notify:

Name \_\_\_\_\_ Relationship to you \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Business Phone \_\_\_\_\_

INSURANCE CARD INFO: If you should become ill or injured and need off campus medical care, x-rays or lab work, you will be required to have a copy of the front and back of your insurance card. Other than life threatening situations, without your card, most facilities will require you to pay for the entire cost of the visit at the time of service and / or run the risk of not being seen.

Insurance Company \_\_\_\_\_

Address: \_\_\_\_\_

Effective Date \_\_\_\_\_

Primary Insured Party Name \_\_\_\_\_

Group Number \_\_\_\_\_ ID Number \_\_\_\_\_

## YOUR PERSONAL HEALTH HISTORY

- **ALLERGIES TO MEDICINES, FOOD, OTHER:**  Yes  No If yes please list:

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_ 5. \_\_\_\_\_

- **MEDICATIONS: (Please List all Prescriptions, Over-the-Counter, Vitamins, Herbals, Performance enhancers, etc. you are currently taking.)**

| DRUG NAME & STRENGTH: | DOSE: | DRUG NAME & STRENGTH: | DOSE: |
|-----------------------|-------|-----------------------|-------|
| _____                 | _____ | _____                 | _____ |
| _____                 | _____ | _____                 | _____ |
| _____                 | _____ | _____                 | _____ |
| _____                 | _____ | _____                 | _____ |

- **YOUR MEDICAL HISTORY**

Please circle if you have or, previously exhibited, any conditions / symptoms listed below:

- |                           |                              |                               |                           |
|---------------------------|------------------------------|-------------------------------|---------------------------|
| 1. High Blood Pressure    | 14. Pneumonia                | 27. Ulcers                    | 40. Arthritis             |
| 2. Diabetes               | 15. Persistent Cough         | 28. Hemorrhoids               | 41. Blood Disorder        |
| 3. Cancer                 | 16. Tuberculosis (TB)        | 29. Gallbladder Disease       | 42. Sickle Cell           |
| 4. Heart Disease          | 17. Asthma                   | 30. Hepatitis / Liver disease | 43. Blood Clots           |
| 5. Shortness of Breath    | 18. Hay fever                | 31. Thyroid Disease           | 44. Anemia                |
| 6. Swollen Ankles         | 19. Indigestion / Heartburn  | 32. Seizures                  | 45. Anxiety               |
| 7. Palpitations           | 20. Abdominal Discomfort     | 33. Headaches                 | 46. Depression            |
| 8. Lightheadedness        | 21. Change in appetite       | 34. Incontinence              | 47. Skin Diseases         |
| 9. Stroke                 | 22. Constipation or diarrhea | 35. Kidney Diseases           | 48. Hearing difficulty    |
| 10. High Cholesterol      | 23. Unexplained weight gain  | 36. Kidney Stones             | 49. Gout                  |
| 11. Chest / Discomfort    | 24. Unexplained weight loss  | 37. Difficulty urinating      | 50. Low back problems     |
| 12. Fever, chills, sweats | 25. Blood in stool           | 38. Urine infections          | 51. Glasses or contacts   |
| 13. Body Art              | 26. Chickenpox               | 39. Mononucleosis             | 52. Glaucoma or cataracts |

Any problems not listed above: \_\_\_\_\_

Do you have any special spiritual, religious, or cultural needs?  No  Yes Explain \_\_\_\_\_

Are you on a special diet?  Yes  No If so, what type? \_\_\_\_\_

- **VACCINATION HISTORY**

|                      |                              |                             |             |
|----------------------|------------------------------|-----------------------------|-------------|
| Tetanus Immunization | <input type="checkbox"/> Yes | <input type="checkbox"/> No | When? _____ |
| Flu Immunization     | <input type="checkbox"/> Yes | <input type="checkbox"/> No | When? _____ |
| Meningitis           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | When? _____ |

OPERATIONS: \_\_\_ No \_\_\_ Yes (please list)

OTHER HOSPITALIZATIONS: \_\_\_ No \_\_\_ Yes (please list)

| TYPE OF OPERATION | WHEN |  | REASON | WHEN |
|-------------------|------|--|--------|------|
|                   |      |  |        |      |
|                   |      |  |        |      |
|                   |      |  |        |      |
|                   |      |  |        |      |

• **FEMALE HISTORY**

Date of last menstrual period \_\_\_\_\_

**FAMILY HISTORY: Has any member of your family (including parents, grandparents, and siblings) had the following?**

| Illness                                             | Which Family Member | Approximate Age When Diagnosed |
|-----------------------------------------------------|---------------------|--------------------------------|
| Cancer (describe type)                              |                     |                                |
| High Blood Pressure                                 |                     |                                |
| Heart Disease                                       |                     |                                |
| Diabetes                                            |                     |                                |
| Stroke                                              |                     |                                |
| Mental Illness (anxiety, depression, etc)           |                     |                                |
| Blood / Clotting disease                            |                     |                                |
| Anorexia / Bulimia (circle all that apply)          |                     |                                |
| Addiction / Drugs / Alcohol (circle all that apply) |                     |                                |
| Sudden Death                                        |                     |                                |
| Overweight                                          |                     |                                |
| Other:                                              |                     |                                |

**PREVENTION HISTORY**

- Do you smoke or use tobacco products?     Yes     No    Type \_\_\_\_\_ Packs per day? \_\_\_\_\_ Quit? \_\_\_\_\_
- Do you drink alcoholic beverages?     Yes     No    How many? \_\_\_\_\_ How often? \_\_\_\_\_
- Do you exercise?     Yes     No    How many times / week? \_\_\_\_\_
- Do you wear seat belts?     Yes     No
- Do you wear a bicycle or motorcycle helmet?     Yes     No

Have you ever used, or are you using drugs? (marijuana, cocaine, crack, etc)?     Yes     No

If Yes please list: \_\_\_\_\_

Any behaviors which would increase your risk of AIDS? (IV drug use, unprotected intercourse, same sex relationship)

Yes     No    If yes, list \_\_\_\_\_

- Do you own a gun?     Yes     No
- Are you an organ donor?     Yes     No
- Have you ever been emotionally, physically or sexually assaulted?     Yes     No

Please sign below:

\_\_\_\_\_ Signature

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date