



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. 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 for information on the waiver process.

I
N
S
U
R
A
N
C
E

P
H
O
T
O
G
R
A
P
H

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.

P
H
O
T
O
G
R
A
P
H

Continued on Page 2

CONFIDENTIALITY NOTICE The information contained on this health form is legally privileged and confidential and is intended only for the use of the UCI-Student Health Center. The copying or distribution of this document is prohibited.

PERSONAL HEALTH HISTORY Complete legibly in black ink

1. Allergies Yes ___ No ___

a. To which drugs _____

b. To which environmental allergens _____

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.

<input type="checkbox"/>	Chickenpox	<input type="checkbox"/>	Rubella (German measles)	<input type="checkbox"/>	Polio
<input type="checkbox"/>	Mumps	<input type="checkbox"/>	Measles (Rubeola)	<input type="checkbox"/>	Infectious mono
<input type="checkbox"/>	Diphtheria	<input type="checkbox"/>	Whooping cough	<input type="checkbox"/>	Rheumatic fever

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

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

2. Lifestyle

Check if you use the following.

<input checked="" type="checkbox"/>	Substance	Quantity/Frequency
<input type="checkbox"/>	Tobacco	
<input type="checkbox"/>	Alcohol	
<input type="checkbox"/>	Caffeine	
<input type="checkbox"/>	Nonprescription steroids	
<input type="checkbox"/>	Recreational drugs - Specify:	
<input type="checkbox"/>	Other:	

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