CENTER FOR HEALTH & COUNSELING
Salt Lake Community College

Medical History Form

Name _________________________________ DOB: __/__/____ Best contact number: ___________________ Today's Date ____/____/____

It is the philosophy of the staff of SLCC Student Health Clinic to provide you with the best care possible. To accomplish this, it is important for us to review significant health issues that might impact your health. **This history form is a confidential document that will be kept in your medical record in the SLCC Student Health Clinic. No information may be released without your written consent, unless required by law.**

Allergies (include medication, foods, and environmental allergies):

____

Medications:

____

Have you **EVER** had an intermittent or chronic medical problem: (*examples*: asthma, high blood pressure/ heart or circulatory disease, lung, kidney, thyroid, depression, etc.):

____

____

____

Previous ***Illness***/Hospitalizations please include month/year:

____

____

____

ANY Surgeries/Procedures or trauma (broken bones, head injury) etc: (year & reason):

____

____

____

Please check the following:

☐ Single ☐ Lifetime Partner ☐ Married ☐ Divorced☐ Separated☐Widow

I live in a(n) ☐ house ☐ apartment ☐ other with_____________ ☐ alone.

Is English your primary language? ☐ Y ☐ N List________________

Ethnicity:_________________ School Major:__________________

Current or past work occupation(s): ______________________

Are you still or were you ever in the military? ☐ Yes ☐ No

Confidential sexual history:

Have you ***ever*** had sexual contact or sexual intercourse? ☐ Y ☐ N

if yes, how many total partners have you had in your lifetime? ______

How many partners in the last 90 days? _______

Have your sexual partners been: ☐ Men ☐ Women ☐ Both

# of pregnancies?______ #Live Births_______

Ages of children ______________________

Pregnancy/Delivery Probs?_______________________________

Are you presently using a birth control or method? ☐ Yes ☐ No

What type? _________________________

Do you wish to become pregnant or are you actively trying to conceive? ☐ Yes ☐ No

Do you drink alcohol? Y N if yes: /day/week
Do you use pot/meth/cocaine/other? Y N if yes: /day/week
Have you ever had an addiction or are you currently recovering from alcohol or drug use? Y N If so, please list when:
Tobacco: Current use: Y N type: frequency: Past use: Y N List quitting month/year ☺:

Please rate your activity/exercise level above your normal daily routine:

Very Active Active Mildly active No additional exercise

Please rate your perception of your diet and nutrition level taking into account amount of calories, types of calories, eating frequency, fast food, etc:

Poor Fair Good Very Good

Please answer the following questions regarding prevention activities:

-How often do you brush your teeth per day?____________________

Do you…

Always wear a seatbelt while riding in a vehicle? ☐ Y ☐ N ☐ N/A

Always wear a helmet if you ride a bike/motorbike? ☐Y ☐ N ☐ N/A

Use designated drivers/call a taxi if drinking alcohol? ☐Y ☐ N ☐ N/A

Perform a monthly breast self exam? ☐ Y ☐ N ☐ N/A

Perform a monthly testicular self exam? ☐ Y ☐ N ☐ N/A

Over the past two weeks, how often have you been bothered by any of the following problems:

1. Little interest or pleasure in doing things (circle):

   Not at all Several Days Over half the days Nearly every day

2. Feeling down, depressed or hopeless (circle):

   Not at all Several Days Over half the days Nearly every day

Check the box if you have had the following screening tests/exams & indicate year. Please indicate "never" if you haven't had that exam.

Dental exam: ☐	Eye exam: ☐
STD testing (if <25): ☐	Pelvic Exam/Pap: ☐
Mammogram: ☐	Prostate Test/exam: ☐
Cholesterol test: ☐	Colonoscopy/Sigmoid: ☐
Tuberculosis skin test : ☐ Have you traveled >2 mo. outside the U.S.?	

Did you receive immunizations in childhood? Yes ☐ No ☐ UNK ☐

Please check off any of the following immunizations you recall receiving including an estimate of year:

Tetanus : **Year** of last shot:	<5 years <10 years >10 years	
Hepatitis B: ☐1st	☐ 2nd	☐3rd
MMR: ☐1st	☐2nd	
HPV vaccine: ☐1st	☐2nd	☐3rd
Pneumonia (pneumovax):	Flu:	
Shingles/Herpes Zoster:	Other:	

Family History:

☐ Heart disease or disorder
☐ Diabetes
☐ Cholesterol (family history)
☐ Hypertension/High Blood Pressure
☐ Anemia
☐ Epilepsy/Seizures
☐ Autoimmune diseases
☐ Depression/Anxiety
☐ Substance abuse
☐ Severe allergy
☐ Liver disease/Hepatitis
☐ TB (Tuberculosis)
☐ Kidney disease
☐ Cancer: Type: ___________
☐ Thyroid disease/disorder
☐ Other
☐ Unknown

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