2100 Moorpark Avenue, Room SC109, San Jose, CA 95128 Phone: 408.288.3724 Fax: 408.297.4865

San Jose/Evergreen Community College District
San Jose City College Student Health Services
MEDICAL HISTORY FORM

Last Name First Name Middle Birthdate

Sex Country of Birth Marital Status Social Security Number

Address City State ZIP

( ) - ( ) -
Home Phone Cell/Work Phone Occupation

☐ Caucasian ☐ African American ☐ Asian/Pacific Islander ☐ Hispanic
☐ East Indian ☐ Native American ☐ Other, please specify:

IN CASE OF AN EMERGENCY, NOTIFY:

( ) -
Name Relationship Phone Number

PERSONAL PHYSICIAN:

( ) -
Name Location Phone Number

Type of insurance Do you have Medi-Cal?:

Has anyone family member (children, parent, sibling, and/or grandparent) ever had:
☐ Abnormal bleeding ☐ Diabetes ☐ Tuberculosis ☐ Kidney disease
☐ Sickle cell anemia ☐ Stroke ☐ Heart Trouble ☐ Epilepsy
☐ Drug/Alcohol abuse ☐ Cancer ☐ Mental Illness ☐ Asthma
☐ Ulcer or Gallbladder disease

List all operations and your age at the time of the operation: _____

Were you ever hospitalized for any other reason?: _____

ALLERGIES
Do you have any allergies to any drugs of medications?: Y N If yes, please specify all drugs and medications you are allergic to.: _____

Any other allergies? : Y N List any routine medications you take: _____
Do you take any health supplements?: Y N If yes, which one(s)?: _____
Do you use any medical devices? (wheelchair, pacemaker, crutches): Y N If yes, which one?:_____

IMMUNIZATIONS:

Last TB test: Last Hepatitis B Shot: Last Tetanus Shot:

SOCIAL HISTORY:

Do you (check all that apply):

☐ Smoke ☐ Drink Coffee ☐ Exercise

☐ Drink Alcohol ☐ Use Drugs ☐ have any children. How many?

Are you sexually active? : Current sex partner is (circle one): Male Female

Have you ever had trouble with: (check all that apply)

☐ Anemia ☐ Heart Attack ☐ Goiter ☐ Rash/Mole Change

☐ Stroke ☐ Palpitations ☐ Rheumatic Fever ☐ Gonorrhea

☐ Syphilis ☐ Herpes ☐ Chlamydia ☐ Gallbladder disease

☐ Hemorrhoids ☐ Nausea/Vomiting ☐ Tuberculosis ☐ Breast disease

☐ Hepatitis ☐ Weight Problem ☐ Back Trouble ☐ Tumors or Cancer

☐ Broken Bones ☐ Polio or Cerebral Palsy ☐ Muscular Dystrophy

☐ Psychiatric Problem ☐ High Blood Pressure

☐ Diabetes/Pre-diabetic ☐ Heart Murmur/Heart Disease

☐ Jaundice/Liver Problem ☐ Gout/Arthritis/Joint Pain

☐ Severe Headache/Migraine ☐ Loss of hearing/ear disease

☐ Problems seeing/Eye disease ☐ Varicose veins/phlebitis

☐ Menstrual disorders(unusual vaginal bleeding) ☐ Ulcers/Abdominal pain

☐ Allergies/hay fever ☐ Asthma/Wheezing/Coughing

☐ Difficulty breathing ☐ Pneumonia/Lung disease

☐ Depression or Tearfulness ☐ Drug or Alcohol problem

☐ Rashes/Hives/Dermatitis ☐ Dizziness or Passing Out

☐ Head injury/Concussion ☐ Seizures or Epilepsy

☐ Kidneys or Bladder infection ☐ Nervousness/Anxiety/Stress

☐ Diarrhea/Constipation

For all checked disorders, briefly explain and include at what age: _____

_____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES (HIPAA): I have received the Notice of Privacy Practices and I have been provided an opportunity to review it. Initial: _____

CONSENT FOR TREATMENT: In the case of routine health examinations, immunizations, diagnostic procedures, treatment of illness and/or injuries, permission is hereby granted to treat the student named below at the Student Health Services, San Jose/Evergreen Community College District, and to make necessary referrals to private physicians and other community facilities as indicated.

OUT-OF-CLINIC SERVICES: I certify that I have been informed that payment for any medical services (including laboratory and X-ray examinations) performed by a non-health center physician or medical facility is my responsibility even though it may be recommended by a health center physician or nurse.

_____ _____

Signature of Student Date

_____ _____

Signature of Witness Date