Student Health & Wellness Center

Potential billing costs: Please review our Costs of Services sheet that outlines when SHW bills your insurance and when you may incur out-of-pocket costs. Most primary care services done at Student Health are billed to insurance, but have no out-of-pocket cost to you. **Pre-entrance or travel vaccines, labs, imaging, referrals to specialists, and any care performed outside of Student Health are subject to insurance benefits and any remaining balance would be your responsibility.** Please ask our front desk team, your provider, or refer to our Costs of Services sheets if you have any questions or concerns about billing.

Name you go by: _____ **Date of birth:**_____

Pronouns you use: ☐ She/Hers ☐ He/His ☐ They/Theirs ☐ Another_____

Why are you seeking care today?

_____

PAST MEDICAL HISTORY

Condition:	**Age of diagnosis:**
_____	_____
_____	_____
_____	_____
_____	_____

PAST HOSPITALIZATIONS

Reason(s):	**Date(s):**
_____	_____
_____	_____
_____	_____

PAST SURGERIES

Procedure(s):	**Date(s):**
_____	_____
_____	_____
_____	_____

PAST PAP SMEARS (if applicable)

Date: _____ Result: _____

Have you ever had an abnormal pap? ☐Yes ☐No

ALLERGIES

Allergy:	**Reaction(s):**
_____	_____
_____	_____
_____	_____

MEDICATIONS/HERBS/VITAMINS/SUPPLEMENTS

Medication and strength:	**Frequency:**
_____	_____
_____	_____
_____	_____
_____	_____

FAMILY MEDICAL HISTORY

If you were adopted or do not know your family medical history, please check here: ☐

List medical conditions of biologic family members below and age of diagnosis.

Example: Maternal Grandmother, heart attack, 50

Family Member	Condition(s)	Age of Diagnosis
Mother		
Father		
Sibling: brother/sister		
Child: son/daughter		
Maternal Grandmother		
Maternal Grandfather		
Paternal Grandmother		
Paternal Grandfather		

SOCIAL HISTORY

Gender Identity: ☐ Female ☐ Male ☐ Transgender Female/Male-to-Female

☐ Transgender Male/Female-to-Male ☐ Other ☐ Choose not to disclose

Sex assigned at birth: ☐ Female ☐ Male ☐ Unknown ☐ Not recorded on birth certificate

☐ Choose not to disclose ☐ Uncertain

Are you a student or Postdoctoral Scholar? If you are a student, what program are you in/what year? _____

☐ Yes ☐ No

☐ **Do you currently suffer with or have you ever suffered in the past with an eating disorder?** _____

☐ Yes ☐ No ☐ In the past

Do you exercise regularly? ☐ Yes ☐ No

Do you have any special dietary restrictions? ☐ Yes ☐ No

If yes, describe: _____

Do you use nicotine products? ☐ Yes ☐ No

*If yes, what type(s):*_____

Are the guns in your home stored safely?

☐ I don't own any guns ☐ Yes ☐ No ☐ I don't know ☐ Prefer not to answer

If you are here for a genital, rectal, breast, or full body skin exam, would you like a chaperone in the room during the exam?

☐ Yes ☐ No

You only need to complete the next page if you are here for physical/wellness exam or gynecologic exam.

HEALTH MAINTENANCE

If you have had any of the following tests or vaccines, please let us know (including the month and year received).

Cholesterol screening: _____ Diabetes screening: _____

Flu vaccine: _____ Pneumonia vaccine: _____

HPV Vaccine series: _____

SEXUAL HISTORY

Are you currently sexually active? □ Yes □ No

If no, have you been sexually active in the past? □ Yes □ No

Sexual Orientation: □ Gay □ Lesbian □ Straight □ Bisexual □ Queer □ Pansexual

☐ Asexual □ Don't know □ Choose not to say □ Another _____

Do you and your sexual partner(s) practice safe sex? □ Yes □ No □ Not sure

Have you had a new sexual partner in the last year? □ Yes □ No

Do you have or have you ever had:
☐ HIV □ Hepatitis B □ Hepatitis C □ Chlamydia □ Gonorrhea □ Herpes □ Syphilis
☐ Trichomonas □ Pelvic Inflammatory Disease (PID) □ Genital Warts

Would you like a STD screening today? □ Yes □ No

Do you feel safe in your relationship? □ Yes □ No □ Not applicable

Within the past year, have you been hit, slapped, kicked or otherwise physically hurt by someone? □ Yes □ No

Has anyone forced you to have sexual activities that made you feel uncomfortable?
☐ Yes □ No

GYNECOLOGICAL HISTORY

Do you plan on becoming pregnant in the next year? □ Yes □ No
What method are you using now, if any? (If using the pill, what brand? If IUD, which one?)
_____

Number of pregnancies: _____ **Number of births:** _____

Have you had a mammogram? □ Yes □ No

If yes, when? _____ *Results:* □ Normal □ Abnormal

MENSTRUAL HISTORY

Age of onset: _____ **Length of menses:** _____
Time between menses: _____ **Date of last menses:** _____