California State University San Marcos

Health History and Treatment Consent

Date_____ Student I.D. # _____ Date of Birth_____

Full Name (First & Last) _____ Preferred Name_____ Pronouns _____

Sex at Birth *(Male, Female, Intersex, etc.)*: _____ Prefer Not to Respond _____

Gender Identity *(Male, Female, Transgender, Non-binary/non-conforming, etc.)*: _____Prefer Not to Respond ____

Telephone: Home _____ Cell _____

Do you authorize Student Health and Counseling Services, Cal State San Marcos to leave detailed voicemails about visits or lab results? Yes ☐ No ☐

If so, which phone number is best to leave the detailed voicemails on (home, cell, both) _____

MEDICAL HEALTH HISTORY

Have you ever been diagnosed and/or treated for any of the following? (Select all that apply)

Allergies		Hemorrhoids/Rectal Issues		Tuberculosis	
Anemia		High Cholesterol		Jaundice or Hepatitis	
Arthritis		High/Low Blood Pressure		Kidney/Bladder/Urine Infections	
Asthma		HIV/AIDS		Kidney Stone or Blood in Urine	
Cancer		ADD/ADHD or Other Learning Disability		Malaria	
Chickenpox		Anxiety/Panic Disorder		Measles/Mumps/Rubella	
Diabetes		Bipolar Disorder		Meningitis	
Dizziness/Fainting		Depression		Orthopedic/Back/Bone Issues	
Ear/Nose/Throat Issues		Drug/Tobacco/Alcohol Abuse		Paralysis (including partial)	
Epilepsy/Seizures		Eating Disorder		Physical Disability	
Eye/Vision Difficulties		Emotional, Verbal or Physical Abuse		Skin Disease	
Frequent or Severe Headaches		Other Psychological or Emotional Disorder		STI-Chlamydia, Gonorrhea, etc.	
Growth or Cyst		PTSD		Stomach/Digestive Issues	
Head Injury/Concussions		Sexual Abuse		Thyroid Disorder	
Heart Issues		Insomnia/Sleep Issues			

Do you have any other current or ongoing medical problems the provider should know about? Yes ☐ No ☐

If Yes, please specify: _____

_____

Have you ever been hospitalized or had any surgeries? Yes ☐ No ☐

If Yes, please specify: _____

_____

Do you have any allergies (medications, food, materials, etc.)? Yes ☐ No ☐

If Yes, please specify: _____

_____

Current medications (include over the counter medications, vitamins, supplements, herbs, and birth control):

_____

_____

Have you had any problems for which you required the services of a mental health provider? Yes ☐ No ☐

Is the reason for **today's visit** related to having been physically or sexually assaulted? Yes ☐ No ☐

Turn Over to Complete Back

Gynecological History (if applicable):

What was the first day of your last period:_____ When was your last Pap Smear: _____

Do you have any gynecological or menstrual issues (severe cramps, irregular, endometriosis, etc.)? Yes ☐ No ☐

If Yes, please specify: _____

Are you currently on birth control?

If Yes, please specify which type: Pill ☐ IUD ☐ Implant ☐ Shot ☐ Ring ☐ Other ☐_____

Have you ever been pregnant? Yes ☐ No ☐

Number of Pregnancies_____Number of miscarriages_____Number of live births_____Number of abortions_____

Sexual History:

Are you engaging in any type of sexual activity? Yes ☐ No ☐ If yes: Anal ☐ Oral ☐ Vaginal ☐

Age of first sexual encounter:_____ Sex of partner(s):_____

Do you use condoms? Yes ☐ No ☐ If yes: Always ☐ Sometimes ☐

Social History:

Do you drink alcohol? Yes ☐ No ☐ If Yes, approximately how many drinks per week: _____

Do you currently use tobacco products? Yes ☐ No ☐

If Yes: Cigarettes ☐ E-Cigs ☐ Hookah ☐ Chew ☐ Approximately how many packs/times per day:_____

If No: Have you used tobacco products in the past? Yes ☐ No ☐ What year did you quit:_____

Do you currently use Marijuana/THC/CBD products? Yes ☐ No ☐

If Yes: Smoke ☐ Vape ☐ Edible ☐ Other ☐ Please specify:_____

Do you use any other substances? Yes ☐ No ☐ Please specify:_____

Family Health History: Please list any significant health problems, such as attention deficit disorder, blood clot, bleeding disorder, cancer (type), diabetes, heart attack, high blood pressure, high cholesterol, seizures, sickle cell, stroke, thyroid, tuberculosis, anxiety, bipolar disorder, depression, eating disorder, suicide, drug or alcohol problems, or other health problems.

Relationship	Health Problems (please print)	Age of Onset	Cause of Death
Mother	_____	_____	Yes ☐ No ☐
Father	_____	_____	Yes ☐ No ☐
Sister(s)	_____	_____	Yes ☐ No ☐
Brother(s)	_____	_____	Yes ☐ No ☐

☐ do not know my family history.

In the event of an emergency, 911 will be called and we will notify your emergency contact.

Emergency Contact_____ Telephone_____ Relationship_____

In case of illness and/or injury, permission is granted to treat the above-named student at Student Health & Counseling Services, Cal State San Marcos and to make the necessary referrals to outside Physicians and Facilities if necessary. I am aware that I will be financially responsible for any lab treatment and/or medication charges deemed necessary by the provider at the time of service. I have read my Patient Rights & Responsibilities*.

_____ _____

Student's Signature ***Date***

_____ _____

Parent's Signature (if student is a minor) ***Date***

**Patient Rights & Responsibilities available at www.csusm.edu/shcs or at the Student Health front desk.*