Health Questionnaire

Saddleback College Student Health and Wellness Center

Name (Last, First, Middle Initial):			**Today's Date:**
Date of Birth: **Student ID:** **Current Phone:** **May we leave a detailed message?** ☐ Yes ☐ No	**Pronouns:** ☐ He/him/his ☐ She/her/hers ☐ They/them/theirs ☐ Not listed: _____	**Gender:** ☐ Man ☐ Woman ☐ Transgender ☐ Nonbinary ☐ Not listed: _____	**Sex Assigned at Birth:** ☐ Male ☐ Female ☐ Intersex ☐ Not listed: _____
	Emergency Contact Name:	**Relationship:**	**Emergency Contact Number:**
Do you have a Primary Care Provider? ☐ Yes ☐ No **Name/Phone number:**		**Do you have a Psychiatrist or Therapist?** ☐ Yes ☐ No **Name/Phone number:**	
What is the reason for today's visit with the healthcare provider?			

CURRENT MEDICATIONS

Medication Name, Dosage, Frequency	Medication Name, Dosage, Frequency
☐ Check if NONE	

ALLERGIES

Medication/Food/Environmental	Reaction	Medication/Food/Environmental	Reaction
☐ Check if NONE			

MEDICAL HISTORY

☐ Alcohol use disorder	☐ Bleeding problems	☐ Gallbladder disease	☐ High blood pressure	☐ Seizure disorder
☐ Anemia	☐ Blood clots	☐ GERD (reflux)	☐ High cholesterol	☐ Sexually transmitted disease
☐ Anxiety	☐ Cancer: _____	☐ Glaucoma	☐ HIV	☐ Stroke
☐ Arthritis	☐ COPD	☐ Gout	☐ Kidney disease	☐ Thyroid disease
☐ Asthma	☐ Depression	☐ Heart attack	☐ Liver disease	☐ Tuberculosis
☐ Atrial fibrillation	☐ Diabetes	☐ Heart failure	☐ Migraine headache	☐ Other: _____
☐ Bipolar disorder	☐ Drug use disorder	☐ Heart valve disorder	☐ Palpitations	☐ Other: _____

SURGICAL HISTORY

Surgery	Year	Surgery	Year	Surgery	Year

GYNECOLOGICAL HISTORY *(Female only)*

Last menstrual period:	Last Pap smear:	Last mammogram:
Number of pregnancies:	Number of living children:	

FAMILY HISTORY *(Place a ✓ in the box if any of these diseases run in your immediate family)*

	Father	Mother	Brother	Sister		Father	Mother	Brother	Sister
Cancer: _____	☐	☐	☐	☐	Stroke	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	Substance use disorder	☐	☐	☐	☐
Heart disease	☐	☐	☐	☐	Other: _____	☐	☐	☐	☐
Psychiatric disorder	☐	☐	☐	☐	Other: _____	☐	☐	☐	☐

SOCIAL HISTORY *(Leave blank if you prefer not to disclose)*

Are you sexually active? ☐ Yes ☐ No | Do you have sex with: ☐ Men ☐ Women ☐ Both

Current birth control method: ☐ Condoms ☐ Birth control pills ☐ Injections ☐ Hormonal implant ☐ IUD ☐ Other: _____

Do you exercise? ☐ Yes ☐ No Type: _____ How often? _____

Do you have: ☐ High stress level ☐ Sleep problems ☐ Family problems ☐ Marital problems

Are you: ☐ DSPS student ☐ EOPS student ☐ First-generation college student ☐ International student ☐ Veteran/Service member

(Use "✔" to indicate your answer) PHQ-9 **Over the last 2 weeks, how often have you been bothered by any of the following problems?**	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	☐0	☐1	☐2	☐3
2. Feeling down, depressed, or hopeless	☐0	☐1	☐2	☐3
3. Trouble falling or staying asleep, or sleeping too much	☐0	☐1	☐2	☐3
4. Feeling tired or having little energy	☐0	☐1	☐2	☐3
5. Poor appetite or overeating	☐0	☐1	☐2	☐3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	☐0	☐1	☐2	☐3
7. Trouble concentrating on things, such as reading the newspaper or watching television	☐0	☐1	☐2	☐3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	☐0	☐1	☐2	☐3
9. Thoughts that you would be better off dead or of hurting yourself in some way	☐0	☐1	☐2	☐3
FOR OFFICE CODING **Total score _____** =	Add Columns	_____	+ _____	+ _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?
☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

(Use "✔" to indicate your answer) GAD-7 **Over the last 2 weeks, how often have you been bothered by the following problems?**	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	☐0	☐1	☐2	☐3
2. Not being able to stop or control worrying	☐0	☐1	☐2	☐3
3. Worrying too much about different things	☐0	☐1	☐2	☐3
4. Trouble relaxing	☐0	☐1	☐2	☐3
5. Being so restless that it is hard to sit still	☐0	☐1	☐2	☐3
6. Becoming easily annoyed or irritable	☐0	☐1	☐2	☐3
7. Feeling afraid, as if something awful might happen	☐0	☐1	☐2	☐3
FOR OFFICE CODING **Total score _____** =	Add Columns	_____	+ _____	+ _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?
☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

(Use "✔" to indicate your answer) TAPS-1	Daily Or Almost Daily	Weekly	Monthly	Less Than Monthly	Never
In the PAST 12 MONTHS, how often have you used tobacco or any other nicotine delivery product (i.e., e-cigarette, vaping or chewing tobacco)?	☐	☐	☐	☐	☐
In the PAST 12 MONTHS, how often have you had 5 or more drinks (men)/4 or more drinks (women) containing alcohol in one day?	☐	☐	☐	☐	☐
In the PAST 12 MONTHS, how often have you used any prescription medications just for the feeling, more than prescribed or that were not prescribed for you?	☐	☐	☐	☐	☐
In the PAST 12 MONTHS, how often have you used any drugs including marijuana, cocaine or crack, heroin, methamphetamine (crystal meth), hallucinogens, ecstacy/MDMA?	☐	☐	☐	☐	☐

Please check concerns you would like to address ☐ Check if NONE

☐ Feeling aggressive, angry or violent	☐ Difficulty expressing emotions	☐ Concerns about child abuse
☐ Frequent arguments, losing your temper	☐ Being lonely and/or isolated	☐ Parenting concerns
☐ Thoughts of hurting someone else	☐ Recent death or loss of someone	☐ Excessive time online/internet/gaming
☐ Problems with impulsivity	☐ Sexual orientation/gender identity concerns	☐ Financial concerns
☐ Frequent mood swings/instability	☐ Sexual performance concerns	☐ Housing concerns
☐ Difficulty controlling thoughts or actions	☐ Feeling guilty about sexual activities	☐ Legal concerns
☐ Feeling disoriented or feeling suspicious	☐ History of sexual abuse, assault or trauma	☐ Immigration/citizenship concerns
☐ Seeing/hearing things others do not see/hear	☐ History of bullying/being bullied	☐ Other concerns: _____