ASU Health Services
Health History and Screening Form

Arizona State University

Last Name	
First Name	
ASU ID Number	Date of Birth

By what name do you like to be called?

What are your gender pronouns?
(Example: she/her/hers, he/him/his, they/them/theirs)

I live:
- ☐ By myself
- ☐ With family or significant other(s)
- ☐ With roommates

I live:
- ☐ on-campus residence hall
- ☐ other on campus housing
- ☐ off campus

I identify myself as being:
- ☐ single / divorced/ widowed
- ☐ dating
- ☐ married
- ☐ in another type of relationship (for example: open relationship, polyamorous)
- ☐ in a long term relationship with my significant other

Which best describes your student status?

❑International ❑Out of State ❑In State ❑Non Student

In what country were you born?

Primary Language Spoken:
- ☐ English
- ☐ Spanish
- ☐ Chinese
- ☐ Arabic
- ☐ Other _____

Do you feel it would be helpful to have a language interpreter when you come to health services?
❑Yes ❑No

Personal Medical History

❑ **None**

Check any that apply	I have this problem NOW	I had this problem in the PAST
ADHD	❑	❑
Allergies	❑	❑
Anemia	❑	❑
Anxiety	❑	❑
Asthma	❑	❑
Autoimmune Disorders: _____	❑	❑
Blood clots	❑	❑
Cancer: _____	❑	❑
Depression	❑	❑
Diabetes	❑	❑
Gallbladder disease	❑	❑
Headaches	❑	❑
Heart Problems: _____	❑	❑
High Blood Pressure	❑	❑
Mood Disorders (Bipolar, Schizophrenia)	❑	❑
Seizures	❑	❑
Stomach Problems: _____	❑	❑
Thyroid	❑	❑
Other (please list):	❑	❑
	❑	❑
	❑	❑

Surgical History

- ❑ **None**
- ❑ Appendectomy
- ❑ Back Surgery
- ❑ Gallbladder Removal
- ❑ Eye Surgery
- ❑ Ear/Nose/Throat Surgery
- ❑ Hernia Repair
- ❑ Orthopedic/ Joint Surgery:
- ❑ Tonsillectomy
- ❑ Other (please list):

Family History

Do any of the following members of your family have any medical conditions?

❑ Unknown (adopted)

Mother	❑None ❑Medical condition(s):	
Father	❑None ❑Medical condition(s):	
Sister	❑None ❑Medical condition(s):	
Brother	❑None ❑Medical condition(s):	
Others	List relationship	Medical Issue

Have you seen another Doctor or other Health Care Provider in the past 2 years?

❑No ❑Yes (name, type, reason): _____

List all medication /supplements (vitamins, protein, pre-work out, etc.) you are currently taking.

Medication Name	What do you take this for?	Dose and directions if you know them.

List any medical allergies you have

Allergy	What was your reaction?

Vaccines

The following vaccines are recommended for college students. Please include the approximate year you received if known.

HPV (Gardasil) all genders	❑ I received. Year:	❑ I am unsure if I received	❑ I would like information	❑ I would like to receive
Influenza (new vaccine each fall)	❑ I received. Year:	❑ I am unsure if I received	❑ I would like information	❑ I would like to receive
Meningitis ACWY (booster after 16)	❑ I received. Year:	❑ I am unsure if I received	❑ I would like information	❑ I would like to receive
Meningitis B (up to age 24)	❑ I received. Year:	❑ I am unsure if I received	❑ I would like information	❑ I would like to receive
Tetanus (Td/Tdap) in past 10 years	❑ I received. Year:	❑ I am unsure if I received	❑ I would like information	❑ I would like to receive

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Sexual History

The sexual history questions help us provide you with advice about your sexual health

Have you ever had sexual activity with another person?
(Such as: intercourse, oral sex, or masturbation with someone else)
❑Yes ❑**No (skip to the next section below – Health Screenings)***

When you have engaged in sexual activity, what sex has/have your sexual partner(s) been?
- ☐ I have only engaged in sexual activity with people of the Opposite Sex (male with female, female with male)
- ☐ I have only engaged in sexual activity with people of the Same Sex (female with female, male with male)
- ☐ I have engaged in sexual activity with people of Multiple Sexes (sometimes called bisexual/pansexual)

Do you use birth control?
❑No ❑Yes, Which type: _____

How many different sexual partners have you had:
In the past 3 months: _____
In the past year _____
In your entire life _____

Have you ever had screening for sexually transmitted infections like gonorrhea, chlamydia, HIV, syphilis?
- ☐ No
- ☐ Yes. When was you last screening: _____

Have you ever been diagnosed with a sexually transmitted infection?
- ☐ No
- ☐ Yes (which infections)
  - ○ Chlamydia
  - ○ Genital Warts
  - ○ Gonorrhea
  - ○ HIV
  - ○ Herpes in the genital region
  - ○ Molluscum in the genital region
  - ○ Syphilis
  - ○ Trichomonas
  - ○ Other: _____

How often do you think you use condoms or other barrier methods when you engage in sexual activity (oral, vaginal, anal)?
- ☐ Always
- ☐ 75% of the time
- ☐ 50% of the time
- ☐ 25% of the time
- ☐ Hardly ever

Health Screenings*

Over the last 2 weeks how often have you been bothered by any of the following problems?

Little interest or pleasure in doing things	❑ Not at all	❑ Several days	❑More than half the days	❑Nearly every day
Feeling down, depressed or hopeless	❑ Not at all	❑ Several days	❑More than half the days	❑Nearly every day
Trouble falling or staying asleep, or sleeping too much	❑ Not at all	❑ Several days	❑More than half the days	❑Nearly every day
Feeling nervous, anxious or on edge	❑ Not at all	❑ Several days	❑More than half the days	❑Nearly every day
Not being able to stop or control worrying	❑ Not at all	❑ Several days	❑More than half the days	❑Nearly every day
Thoughts that you would be better off dead or of hurting yourself.	❑ Not at all	❑ Several days	❑More than half the days	❑Nearly every day
Are you currently considering hurting or killing someone else?	❑No	❑Yes		

Within the last year have you been		
Humiliated or emotionally abused in other ways by your partner or your ex-partner?	❑No	❑Yes
Afraid of your partner or ex-partner?	❑No	❑Yes
Raped or forced to have any kind of sexual activity by your partner or ex-partner?	❑No	❑Yes
Kicked, hit, slapped or otherwise physically hurt by your partner or ex-partner?	❑No	❑Yes

Tobacco Use

Do you use tobacco? ❑Yes ❑No
Type (vape/cigarettes/cigar/chew)? _____
How often (number per day/week)? _____
Are you interested in quitting? ❑Yes ❑No

Circle the answer the best applies to you.	0	1	2	3	4
How often do you have drinks containing alcohol?	Never	Monthly or less	2 to 3 times per month	2 to 3 times a week	4 or more times a week
How many standard drinks do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more
How often do you have 6 or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily
How many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons?	Never	Monthly or less	2 to 3 times per month	2 to 3 times a week	4 or more times a week

Do you make yourself sick because you feel uncomfortably full?	❑Yes	❑No
Do you worry you have lost control over how much you eat?	❑Yes	❑No
Have your recently lost more than 14 pounds in a three month period?	❑Yes	❑No
Do you believe yourself to be fat when others say you are too thin?	❑Yes	❑No
Would you say food dominates your life?	❑Yes	❑No

Do you use marijuana?
- ☐ No
- ☐ Medical. Reason: _____
- ☐ Non-Medical. Reason: _____

Patient Signature	Date	Nursing Staff Signature (if indicated)	Date

For Office Use Only
- ☐ Health History form reviewed by Nursing
  - ☐ Immediate appointment recommended
  - ☐ Primary Care follow up recommended
  - ☐ Patient reports no concerns at this time

Reviewing Clinician Signature

Date