

**Yuba Community College Health Center  
Medical Health History**

Name:	SS#	Date:
Birth date / / Sex M F Ht.	Wt.	Marital Status: S M D W
Local Address:	Phone:	Cell Phone:
Permanent Address:	Phone:	Work Phone:
Current Medications:	Allergies to Medications or Other:	
Name of Insurance:		
Main Reason for Visit:		

**Past Medical History**

Do you now have or ever been treated for:	Yes	No	If Yes, Date	Do you now have or have you ever been treated for:	Yes	No	If Yes, Date
Alcohol/Drug Dependence				Hepatitis			
Allergy/Hay Fever				High Blood Pressure			
Anemia/Blood Disease				High Cholesterol			
Anxiety				Hypoglycemia			
Arthritis/Joint Pain				Insomnia			
Asthma				Liver Disease/Jaundice			
Back Problem				Malaria			
Bladder/Kidney				Mononucleosis			
Blood in Stool				Pregnancy			
Breast Problems				Psychological Problem			
Cancer/Cyst/Tumors				Respiratory Problem			
Clot in Veins				Rheumatic Fever			
Constipation				Sexually Transmitted Disease			
Depression				Shortness of Breath			
Diabetes (Sugar)				Skin Problem			
Diarrhea				Strep Throat			
Dizziness/Fainting				Swollen Glands			
Ear/Nose/Throat Problem				Swollen Joints			
Epilepsy/Seizures				Thyroid Disease			
Eye Problem				Tuberculosis			
Gallbladder/Intestinal				Ulcer			
Head Injury				Varicose Veins			
Heart Problems				Weight Problem			
Hemorrhoids				Other:			

Please list any surgeries, injuries, or hospitalizations:

Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are your immunizations up to date?
How much per day?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No	
How much per day?	
Do you use recreational drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No	Females Only Section
How much per day?	Age at onset of menses?
Are you sexually active? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of last menstrual period?
Number of partners in last 6 months?	Frequency of menses?
	Duration of menses?

**Family Medical History**

Please list the following family health problems below: Blood clotting problems; cancers of the colon, breast, uterus, ovary, prostate, testicle or any other; heart disease or heart attack; high blood pressure; stroke; diabetes (sugar); thyroid problems; liver and alcohol problems, glaucoma, etc. (Maternal = mother's side of family; Paternal = father's side of family)			
Person	Age	Health Problem	Deceased/Living (D/L)
Mother			
Father			
Maternal Grandmother			
Maternal Grandfather			
Maternal Aunts/Uncles			
Paternal Grandmother			
Paternal Grandfather			
Paternal Aunts/Uncles			
Brothers/Sisters			
Children			

**In Case of an Emergency Notify:**

Name:	Relationship:
Address:	
Phone:	Work Phone:

Resource: With permission from FAO.

**Yuba College Health Center  
Release to Treat**

The previous medical history responses are true and correct to the best of my knowledge. I hereby authorize medical care, including health assessment, treatment, immunizations, and other medical procedures, within the discretion of the health services nurse.

In the event of a serious disease or injury, I hereby consent to emergency treatment necessary to help preserve life or health. If the student is under age 18, it is understood that all reasonable efforts will be made to contact the parent or guardian, should an emergency occur.

I hereby authorize the Health Center to use the above stated health information for any treatment or care. All information will be kept confidential.

Signature of Student \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Parent or Guardian (If student is under 18) \_\_\_\_\_ Date: \_\_\_\_\_