UCSD STUDENT HEALTH SERVICE 0039,
9500 GILMAN DRIVE, LA JOLLA, CA 92093-0039 (858) 534-3300
Please read and complete this form. The information is for the use of Student Health Service.
It is protected, confidential information intended for your medical care.

LABEL

STUDENT INFORMATION

Print Name (Last, First, Middle) | Preferred Name (First) | Date of Birth | Country of Birth

Gender ☐ Male ☐ Female ☐ M → F ☐ F → M ☐ Non-binary

Sex Assigned at Birth ☐ Male ☐ Female

College

☐ Single ☐ Married ☐ Separated/Divorced ☐ Widowed

☐ Undergrad ☐ Grad ☐ Medical School ☐ Pharmacy ☐ Business School

Local / S.D. Address | City | State | Zip

Local phone or cell phone | OK to leave phone message? ☐ Yes ☐ No | Email address | OK to leave email message? ☐ Yes ☐ No | Please be aware that email may not be confidential

Insurance Carrier ☐ SHIP ☐ Other (please specify)

PARENT/GUARDIAN/NEXT OF KIN INFORMATION

Name | Relationship | Home Phone | Alternate Phone

Address | City | State | Zip

EMERGENCY CONTACT (if other than above)

Name | Relationship | Home Phone | Alternate Phone

Address | City | State | Zip

PLEASE MARK BOX IF RESPONSE IS YES. LEAVE BOX OPEN FOR NO

PAST MEDICAL HISTORY - Have you ever had?

☐ ADHD	☐ chickenpox	☐ high cholesterol	☐ sexually trans. infection
☐ allergies/hay fever	☐ colitis	☐ kidney problem	☐ suicide attempt / self-harm
☐ anemia/blood disorder	☐ concussion	☐ liver problem/hepatitis	☐ thyroid problem
☐ anorexia/bulimia	☐ deafness	☐ mental illness (other)	☐ tuberculosis (active)
☐ anxiety or panic disorder	☐ depression	☐ ovarian cysts	☐ ulcer/stomach problems
☐ arthritis	☐ diabetes	☐ pelvic infections	☐ other/list _____
☐ asthma	☐ gall bladder disease	☐ pneumonia	_____
☐ bipolar disorder	☐ headaches (frequent or severe)	☐ pneumothorax	
☐ cancer	☐ heart problem	☐ rheumatic fever	
☐ cerebal palsy/stroke	☐ high blood pressure	☐ seizures	

STAFF NOTES

HOSPITALIZATION/SURGERY

☐ NO ☐ YES, please specify date and reason:

Are you currently under the care of a medical or psychiatric provider? ☐ YES ☐ NO
(please list names and specialty)

CURRENT MEDICATIONS

☐ NO ☐ YES, please specify:

ALLERGIES

☐ NO known allergies ☐ YES, as specified:

☐ penicillin ☐ sulfa ☐ codeine ☐ aspirin/ibuprofen ☐ other drugs _____

☐ bee sting ☐ latex ☐ food allergy _____

Please specify the type of allergic reaction (symptoms) that you had: _____

OFFICE USE ONLY

REV. BY	DATE