BOISE STATE UNIVERSITY

HEALTH SERVICES

New Patient Health History

Name:_______________________________________

University ID:___________________________________

Phone Number:_________________________________

Email Address:__________________________________

Date of Birth: _____/_____/_____ **Sex:** M: □ F: □

Marital Status: Single: □ Married: □ Divorced: □

Long-term illness or condition, or any problem requiring regular treatment/care? (stomach, heart, headaches, weight, mental health/depression, blood pressure, asthma, etc.) None: □

If yes, please list:_________________________________

____

____

Allergies to Medications: None: □

If yes, please list:_________________________________

____

Other Allergies: Seasonal: □ Other: □ None: □

If yes, please list:_________________________________

____

Current Medications *(name, dose)*: None: □

Prescriptions (Includes Birth Control):________________

____

____

Over the counter/herbal:___________________________

____

Past history of serious illness or trauma *(broken bones, concussions, pneumonia, etc.)*: None: □

If yes, please list:_________________________________

____

Has anyone in your family had: cancer, heart disease, high blood pressure, diabetes, thyroid problems, mental illness, or <u>other</u> inherited conditions? None: □

If yes, please list relative & condition:_______________

____

____

Past surgeries and/or hospitalizations (please list with date): ______________________________________

____

____

Past surgeries and/or hospitalizations (please list with date):

____

____

____

Tobacco/Nicotine Use: Never: □ Past: □ Current: □
Type: Cigarettes/Cigar/Pipe: □ Smokeless: □ Vaping: □

Quit when: _________________________________

How many:_______________ Per:_______________

How long:___________________________________

Alcohol Use:

How many drinks do you average in a day? ______ A week? ______

How often do you binge drink (more than 4-5 drinks in one night?

____

Street/Recreational/Illicit Drug Use: No: □ Yes: □

IV Drug Use: No: □ Yes: □

What kind: _________________________________

How much: _________________________________

How long: __________________________________

Screening for anxiety and depression: Over the past **2 weeks**, how often have you been bothered by any of the following items?	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. Little interest or pleasure in doing things	*0*	*1*	*2*	*3*
4. Feeling down, depressed, or hopeless	*0*	*1*	*2*	*3*

***Females Only*:** # of pregnancies: _____ # of live births: _____

Menses regular? No: ☐ Yes: ☐

First day of last menstrual period? _______/_______/_______

Signature: _________________________________

Date:______/______/______