University of La Verne

STUDENT HEALTH SERVICES
HEALTH HISTORY FORM

2147 E Street, La Verne, CA 91750
Studenthealthcenter@laverne.edu

Today's Date _____

Name _____ DOB _____ Student ID _____

Permanent Address _____

Cell Phone _____ Email _____

International Student ☐ Yes ☐ No Are you a US Veteran ☐ Yes ☐ No Gender ☐ Male ☐ Female ☐ Other _____

In case of emergency, notify: _____

Relationship of the emergency contact _____ Phone _____

HEALTH HISTORY

Please explain any YES responses.

1. Do you have any environmental allergies (pollens, trees, grass, etc)? ☐ YES ☐ NO
If yes, please list the allergen and the reaction _____

2. Are you allergic to any medications or latex (penicillin, sulfur, etc)? ☐ YES ☐ NO
If yes, please list the allergen and the reaction _____

3. Do you have any health problems?(asthma, migraine, diabetes, thyroid, anxiety, depression, etc) ☐ YES ☐ NO
Please disclose all _____

4. Do you take medications regularly? (Include prescription, over the counter, supplements and homeopathic medications, birth control pills, etc.) ☐ YES ☐ NO If yes, please list and indicate dosage. _____

FAMILY HISTORY

1. Have any of your relatives had significant health problems? (e.g. heart attack, diabetes, high blood pressure, psychiatric disorders, stroke, seizures, etc.) ☐ YES ☐ NO
If YES, List problems and relative _____

PERSONAL SAFETY

Do you feel safe at home or in your relationship? ☐ YES ☐ NO

IMMUNIZATION HISTORY

1. Have you received the COVID-19 vaccine? ☐ YES ☐ NO
If yes, How many vaccine(s) ☐ 1 ☐ 2 ☐ 3 or more
2. Do you receive an annual flu shot? ☐ YES ☐ NO
3. Have you had the HPV vaccine (Gardasil)? ☐ YES ☐ NO
If yes, have you had all 3 doses? ☐ YES ☐ NO
4. When was your last tetanus or T-DAP shot? _____