



CALIFORNIA STATE UNIVERSITY, LONG BEACH

STUDENT HEALTH SERVICES

Accredited by the Accreditation Association for Ambulatory Health Care, Inc.
1250 Bellflower Boulevard Long Beach, California 90840-0201 (562) 985-4771 Fax: (562) 985-8404

Name _____ CSULB ID # _____
 Local Address _____ Date of Birth _____
 _____ Phone _____ Gender _____
 _____ Age: _____
 In case of emergency, notify: _____ Relationship _____
 Address _____ Phone _____

Medical Insurance
 Are you covered by medical insurance? NO If yes, please list _____

PERSONAL and FAMILY HISTORY
 Have you ever been hospitalized? NO
 If YES, describe & date:

 Have you had surgeries? NO
 If YES, describe & date: _____

 Have any of your relatives had serious medical illness? (e.g. heart attack, diabetes, high blood pressure, psychiatric disorders, stroke, seizures, etc.) NO
 If YES, describe & date:

HEALTH HISTORY
Please explain any YES responses. Use back of sheet, if needed.
 Are you allergic to any medications?
 NO YES, please list.

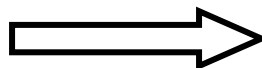
 Do you have any significant health problems? (e.g. allergies, asthma, migraine, heart, gastrointestinal, psychological disorders)
 NO YES, please list

 Do you take medications regularly? (Include prescription, non-prescription, supplements and homeopathic medications, birth control pills, etc.)
 NO YES, please list

PERSONAL SAFETY
 We at the Student Health Center are concerned about verbal, physical and sexual abuse issues and their impact on our patients. Would you like to discuss this issue with an experienced counselor?
 YES NO

Tobacco use: Current smoker How much do you smoke? _____ cig's/day Number of years? _____
 Are you interested in speaking with a counselor on smoking cessation? YES NO
 Non Smoker
 Former Smoker Quit Date _____
Other tobacco use: chew pipe cigar snuff
Alcohol use: Do you drink alcohol? YES NO Number of drinks/wk _____
 Is your alcohol use a concern for you or others? YES NO
Drug use: Do you use recreational or street drugs? YES NO
 Are you interested in speaking with a counselor on substance abuse? YES NO

Clinician's Initials: _____



Authorization and Consent for Treatment

I hereby give consent to the medical staff at the CSULB Student Health Center for medical examination and treatment. This includes lab and x-ray tests, medications and immunizations or any other care when deemed advisable by, and rendered under the general supervision, of a clinician licensed under the provision of the California Medical Practice Act. I understand that treatment will be completely confidential and my records will not be released to anyone without my permission except by subpoena and legal required morbidity reporting.

Student Signature: _____ Date: _____

Student ID# _____

Please Initial: _____ I authorized the SHS to release, to me for my personal use, copies of lab results, x-ray results, and immunization records at my request.