**leming**

Health Services

**Student Health Center**

Personal Health History Questionnaire

**UCSC Student Health Center**

**Personal Health History Questionnaire**

Please take the time to carefully complete the information below. This form along with any documentation recorded during your visit to the clinic will be kept on file for a period of fifteen years. Please be sure to contact Health Services immediately should any of this information change, so that our records are up-to-date.

**PERSONAL INFORMATION (please print)**

|  |  |  |
| --- | --- | --- |
| Last Name First Name (as they appear on health card) | Date of Birth  (dd/mm/yyyy) | Program |
| Preferred Name(s) | Gender  (how do you identify) | Student ID Number |
| Health Card Number Version Code (letters at end of number) | Telephone Number | Leave a message yes □ no □ |
| Local Address  Street City Postal Code | Emergency Contact (Parent or person with a permanent phone #)  Relationship (ie parent/spouse/relative/friend) | |
| Family Physician | Phone | Address |

**Present Medical Conditions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**MEDICATIONS and Reason for Medications**

List all prescription and over the counter medications, herbs and vitamins you take on a regular basis **(Name/frequency/Reason):**

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**ALLERGIES**

List names of medicines, foods, latex, insect bites or environmental allergies that have resulted in an unfavourable reaction. **State reaction.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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SEE OVER->

Additional Information you would like us to know about you that may relate to your care:

**Privacy and Confidentiality**

Fleming College Health Services’ staff are bound by condition of employment, law and ethics to safeguard your privacy and confidentiality of your personal information. As of January 2020, all student health records will be **stored electronically**. We will only collect the information that may be necessary for your circle of care; keep accurate and up-to-date resources; safeguard the health records in our possession; share information with other healthcare providers on a “need to know only” basis, where required for your healthcare; disclose information to third parties ONLY with your signed, written consent or when legally required; retain and destroy records in accordance with the law. Your request for care from Health Services implies consent for the collection, storage, use and disclosure of your personal information for purposes related to your provider if you have concerns about the accuracy of your records. Health Services requires the client to provide their student number, address, phone number, date of birth and health card number.

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Patient Name (please print) Patient Signature Date