

UCSD Student-Run Free Clinic Project Patient Enrollment Form

I. General Information

Name: _____ Address or Sleeping Location: _____
First Last

City: _____ Zip Code: _____ Phone Number: (____) _____ Ext _____

Emergency Contact Information: _____
Name Phone Number/Address Relationship

Male Female Today's Date: ___/___/___ Date of Birth: ___/___/___ Age: ___

Ethnicity: Hispanic African-American Asian-American Caucasian Native American Other _____

Homeless Status: No Yes (If yes, How long?) _____

Primary Language: English Spanish French Chinese Japanese Vietnamese Other _____

Education Level: Elementary Junior High High School Bachelor M.A/PhD Other _____

Insurance Coverage: Yes No *If yes Please mark which insurance:*
 Medicare MediCal CMS CMH VA Other PPO Other HMO

Marital Status: Single Married Separated Divorced Widowed

Number of Children: _____ Children under 12 living at home: _____

Employment Status: Employed Unemployed Seeking Employment Retired Homemaker

What are your main health concerns? _____

What other problems are you facing? _____

What brings you here today? _____

II. Family Medical History

Is mother alive? Yes No *If no* Cause of death: _____ Age of death: _____

Is father alive? Yes No *If no* Cause of death: _____ Age of death: _____

Please check the box if any of these illness relate to your mother, father or sibling.

	Mother	Father	Siblings		Mother	Father	Siblings
High Cholesterol(HL)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure-HT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other Cancers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coronary Artery Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Clotting Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

****Please complete the back page****

III. Personal Medical History

Medications (*Dosage and frequency*): _____

Allergies: _____

Hospitalizations: _____

Surgeries: _____

Please check the box of each illness that you have had.

Childhood Diseases	Hematological	Neurological	GU/Renal
Measles <input type="checkbox"/>	Thalasseima <input type="checkbox"/>	Parkinson Disease <input type="checkbox"/>	Renal Failure <input type="checkbox"/>
Mumps <input type="checkbox"/>	Anemia <input type="checkbox"/>	Seizure Disorder <input type="checkbox"/>	Benign Prostatic <input type="checkbox"/>
Rubella <input type="checkbox"/>	Clotting Disorder <input type="checkbox"/>	Migraine <input type="checkbox"/>	Hypertrophy <input type="checkbox"/>
Whooping Cough <input type="checkbox"/>	Psych/Substance Abuse	Ophthalmologic	Immunological
Rheumatic Fever <input type="checkbox"/>	Schizophrenia <input type="checkbox"/>	Diabetic Retinopathy <input type="checkbox"/>	Lupus/SL <input type="checkbox"/>
Scarlet Fever <input type="checkbox"/>	Bipolar <input type="checkbox"/>	Glaucoma <input type="checkbox"/>	Arthritis <input type="checkbox"/>
Polio <input type="checkbox"/>	Anxiety Disorder <input type="checkbox"/>	Cataracts <input type="checkbox"/>	Osteoarthritis <input type="checkbox"/>
Cancers	Alcoholism <input type="checkbox"/>	Cardio/Neuro Vascular	
Colon Cancer <input type="checkbox"/>	Drug Dependence <input type="checkbox"/>	Hypertension <input type="checkbox"/>	
Liver Cancer <input type="checkbox"/>	Infections	Emphysema <input type="checkbox"/>	
Lung Cancer <input type="checkbox"/>	HIV and/or AIDS <input type="checkbox"/>	Angina <input type="checkbox"/>	
Melanoma <input type="checkbox"/>	Chicken Pox <input type="checkbox"/>	Heart Failure <input type="checkbox"/>	
Other Skin Cancers <input type="checkbox"/>	Hepatitis A <input type="checkbox"/>	Stroke (CVD) <input type="checkbox"/>	
Breast Cancer <input type="checkbox"/>	Hepatitis B <input type="checkbox"/>	Peripheral Vascular Disease <input type="checkbox"/>	
Prostate Cancer <input type="checkbox"/>	Hepatitis C <input type="checkbox"/>	Respiratory	
Endocrine	Syphilis <input type="checkbox"/>	Emphysema <input type="checkbox"/>	
Hyperthyroid <input type="checkbox"/>	Gonorrhea <input type="checkbox"/>	Asthma <input type="checkbox"/>	
Hypothyroid <input type="checkbox"/>	Chlamydia <input type="checkbox"/>	GI	
Diabetes <input type="checkbox"/>	Tuberculosis <input type="checkbox"/>	GERD <input type="checkbox"/>	
High Cholesterol <input type="checkbox"/>		Cirrhosis <input type="checkbox"/>	

Other Illnesses: _____

IV. History of Substance Abuse

Drug	Past Use	Current Use	Never	Tobacco: Packs per day: _____
Marijuana	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Years of smoking: _____
Methamphetamine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol: Drinks per day: _____
Cocaine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Domestic violence:
Heroin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Current <input type="checkbox"/> Past <input type="checkbox"/> Never <input type="checkbox"/>
Designer Drugs/OTC Medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
IV Drug Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

V. Sexual History

Sexually active: Yes No Sexual preference: Men Women Both #Lifetime sexual partners: _____

Contraception: Condoms Birth Control Pill Intrauterine Device Diaphragm Spermicide

Vasectomy/Tubal None

Office use only:

Reviewed by: _____ / /

Name

Date