Pasadena City College
Student Health Services
1570 E. Colorado Blvd. D-105
Pasadena, CA 91106

HEALTH QUESTIONNAIRE Part I

_____
Last eight digits of Student ID Number

Birthdate:_____ Age:_____

USE BLACK INK ONLY and PRINT CLEARLY

Height:_____ Weight:_____

Name: _____ Preferred name: _____
Last First

Address: _____
Street City State Zip Code

Contact Phone: _____ May we leave confidential voice messages? ☐ Yes ☐ No
Cell or Phone

May we send confidential text messages? ☐ Yes ☐ No

e-mail: _____ May we e-mail confidential messages? ☐ Yes ☐ No

What is your gender identity? ☐ Male ☐ Female ☐ Non-binary ☐ Other_____ ☐ Decline to state

Do you identify as transgender? ☐ Yes ☐ No ☐ Not sure ☐ Decline to state

Are you an International Student (F1)? ☐ Yes ☐ No Are you a U.S. Veteran? ☐ Yes ☐ No

Known Drug Allergies: ☐ No ☐ Yes:_____

Other Allergies: ☐ No ☐ Yes:_____

Do you take any Medications/Non-prescription/Herbs? (Please include dosage and number of times taken each day):

☐ No ☐ Yes: _____

History of any of the following:	Yes	No
Allergies/Hay Fever		
Attention Deficit/Hyperactivity Disorder		
Anxiety, Depression, or Bipolar Disorder		
Blood Disorder (e.g. anemia, leukemia)		
Cancer of any type		
Cholesterol or lipid problems		
Convulsions, seizures (epilepsy)		
Diabetes		
Digestive Tract Disease (e.g. ulcer, colitis)		
Eating Disorder (e.g. anorexia/bulimia)		
Eye Disorder (e.g. infection, vision change)		
Wear Contacts or Glasses?		
Heart Disease (e.g. rheumatic fever, murmur)		
Headaches (e.g. migraine, tension)		

History of any of the following:	Yes	No
High Blood Pressure		
Lung Disorder (e.g. asthma, bronchitis, tuberculosis)		
Orthopedic Problems (e.g. broken bones, knee, back)		
Skin Disorder (e.g. rash, eczema, psoriasis)		
Substance Use (e.g. alcohol, drugs, nicotine)		
Thyroid or Endocrine Disorder		
Tobacco Use Ever		
Urinary, bladder, or kidney problems		
Please comment on any yes answers:		
List Surgeries or other Health Issues:		

Person to notify in an emergency: _____ Relationship to you: _____
Name

Contact Phone: _____ Alternate Phone #: _____
Cell or Phone Cell or Phone

Medical Insurance: ☐ No ☐ Yes ☐ Unsure

Insurance Name: _____ M.D.: _____ Phone:_____

Rev. 01/05, 01/09, 12/12, 07/13, 08/16, 02/17, 08/17, 06/19, 07/20 Rev. 03/22 (Update annually/prn)

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HEALTH QUESTIONNAIRE Part II

_____
Last Name, First Name (Please Print)

Birthdate:_____

APPOINTMENT REMINDERS:

We will be sending email reminders for all appointments to the email address provided above. If you **do not** want to receive these reminders please mark the box. ☐ I **DO NOT** wish to receive email reminders

We may implement text message reminders in the future, please provide a text-capable phone number if you wish to receive text reminders. ☐ Same as above OR Phone Number_____

Are you a student with a disability? ☐ Yes ☐ No **If yes, please complete information below:**

Are you currently using the Disabled Student Programs and Services (DSP&S)? ☐ Yes ☐ No

Confidentiality Statement for students using DSP&S:

The DSP&S and Student Health Services staff works as a team to help you meet your educational goals. We may consult with one another and discuss certain aspects and/or relevant medical information to your situation when it is necessary.

Are you in agreement with the team discussing relevant information? ☐ Yes ☐ No _____ **(Initials)**

I understand that if I approve the consultation that I can change my mind at any time and withdraw the approval with a written and signed request. And, if I decline this request for consultation that it will not affect my health care in this health center.

Your Personal Health Information (PHI) is confidential and will not be released or discussed with anyone without your written permission. However, by law there are certain reportable conditions when your PHI disclosure is required to appropriate public health and safety authorities:

1) Reporting abuse or neglect (e.g. child, elder, or dependent adult); reporting occurrences related to preventing/controlling disease or infection exposure/illness; reporting device defects or adverse medication reactions to the Food and Drug Administration.
2) When you communicate that someone is hurting you; or you communicate a direct or indirect threat of hurting yourself or another person.
3) When your medical records are required for a legal proceeding (e.g. subpoena, court order, worker's comp, etc.)

Student Health Services (SHS) provides health care for short-term medical conditions. It is not the intention of SHS to provide medical management of chronic care conditions generally viewed as the practice of primary care providers. If, at any time, it is determined that the health care you need exceeds beyond the clinical practice and/or resources of SHS, we will assist you with a referral for follow-up with appropriate off-campus health care providers.

I consent to receive Telehealth services with the Student Health Services (SHS) staff and providers, which may require me to use electronic devices, such as a smartphone or desktop/laptop with a two-way webcam and audio capability before, during, and after my appointment takes place. I understand that there are inherent risks, benefits, and security limitations to using these e-visit formats, including unsecured privacy at my location, and I voluntarily assume them.

1) I understand that Student Health Services will take all measures possible to keep all my information private and confidential, including encryption and a HIPAA-compliant platform.
2) I consent to have an SHS clinical team member contact me via electronic devices to discuss and review laboratory results (if applicable) during telehealth operations.
3) I will complete the Authorization to Release Health Information form in order to obtain a physical copy of my results and/or medical records via postal mail or fax and submit it to PCC SHS.

A clinician may access and/or enter immunization information into CAIR2 when applicable. The California Immunization Registry (CAIR2) is a secure, confidential, statewide, computerized immunization information system for California residents. If you have any questions, concerns, or would like more information on CAIR2, please discuss with a clinician.

I understand the health center's privacy practices regarding my Protected Health Information (PHI) and consent to treatment and/or referral for care by the clinical and counseling staff.

Signature_____ Student ID_____ Date_____

Rev. 01/05, 01/09, 12/12, 07/13, 08/16, 02/17, 08/17, 06/19, 07/20 Rev. 03/22 (Update annually/prn)