Florida Atlantic University – Student Health Services

Psychiatry Services Health History Form

Patient Information:

Name: _____ Z-Number: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Cellphone: _____ Preferred Name: _____

Sex Assigned at Birth:
☐ Female
☐ Male
☐ Anything Else: _____

Gender Identity:
☐ Woman ☐ Trans Man
☐ Man ☐ Prefer not to say
☐ Gender Queer ☐ Anything else: _____
☐ Trans Woman

What Pronouns do you use?
☐ She/her/hers
☐ He/him/his
☐ They/them/their
☐ Anything else: _____

Ethnicity:
☐ American Indian/Alaskan Native
☐ Asian/Pacific Islander
☐ Black/African American
☐ Hispanic ☐ White

Are you an active duty service member? ☐ No ☐ Yes

Are you a veteran of the U.S. Military? ☐ No ☐ Yes

Are you a dual-enrolled high school student? ☐ No ☐ Yes

Are you FAU staff/faculty member taking courses through the Employee Educational Scholarship Program ☐ No ☐ Yes

Are you FAU staff/faculty member taking courses, *not* through the Employee Educational Scholarship Program ☐ No ☐ Yes

Reason for your visit today:

_____

_____

Mental Health History

Prior Diagnosis: ☐ No psychiatric conditions
☐ Depression ☐ General Anxiety
☐ Bipolar Disorder ☐ PTSD
☐ OCD ☐ Eating Disorder
☐ Schizophrenia ☐ ADHD
☐ Other:

Suicide Attempts:
☐ No ☐ Yes Number of times: _____

Hospitalizations: ☐ No hospitalizations
Date: _____ Where: _____
Date: _____ Where: _____
Date: _____ Where: _____

Prior Medications: _____

_____

Current Medications: _____

_____

Social History

No ☐ **Yes** ☐ Do you smoke/use tobacco products? If yes, how much: _____
No ☐ **Yes** ☐ Do you drink alcohol? If yes, how much: _____
No ☐ **Yes** ☐ Do you use marijuana? If yes, how much: _____
No ☐ **Yes** ☐ Do you use any other drugs? If yes, please list: _____

No ☐ **Yes** ☐ **N/A** ☐ If sexually active is birth control uses? If yes, type: _____
No ☐ **Yes** ☐ **N/A** ☐ Are you currently pregnant, or is there a good chance you are pregnant?
No ☐ **Yes** ☐ Do you have any children? If yes, age & gender: _____

No ☐ **Yes** ☐ Do you feel safe where you live?
No ☐ **Yes** ☐ Do you want to hurt yourself or someone else?
No ☐ **Yes** ☐ Does someone you know make you feel unsafe?
No ☐ **Yes** ☐ Do you have any siblings? ☐ Brothers, how many: _____ ☐ Sisters, how many: _____

Academic Status	Employment Status	Marital Status	Living Situation	Sexual Orientation or Gender Preference	Religious/Spiritual Status
☐ Freshmen	☐ Unemployed	☐ Single	☐ Live alone	☐ Heterosexual	☐ Atheist
☐ Sophomore	☐ Full-Time	☐ Engaged	☐ with Roommates	☐ Homosexual	☐ Agnostic
☐ Junior	☐ Part-Time	☐ Married	☐ with Spouse	☐ Bisexual	☐ Buddhist
☐ Senior	☐ Disabled	☐ Separated	☐ with Family	☐ Transgender	☐ Christian
☐ Graduate Student		☐ Divorced	☐ On Campus		☐ Hindu
		☐ Widowed			☐ Jewish
					☐ Other _____

Trauma History: _____

_____

_____

_____

Family History: *(select all that apply)*							
Mother	☐ None	☐ Depression	☐ Anxiety	☐ Bipolar	☐ Schizophrenia	☐ Drugs	☐ Alcohol
Father	☐ None	☐ Depression	☐ Anxiety	☐ Bipolar	☐ Schizophrenia	☐ Drugs	☐ Alcohol
Sister	☐ None	☐ Depression	☐ Anxiety	☐ Bipolar	☐ Schizophrenia	☐ Drugs	☐ Alcohol
Brother	☐ None	☐ Depression	☐ Anxiety	☐ Bipolar	☐ Schizophrenia	☐ Drugs	☐ Alcohol
Daughter	☐ None	☐ Depression	☐ Anxiety	☐ Bipolar	☐ Schizophrenia	☐ Drugs	☐ Alcohol
Son	☐ None	☐ Depression	☐ Anxiety	☐ Bipolar	☐ Schizophrenia	☐ Drugs	☐ Alcohol
Aunt	☐ None	☐ Depression	☐ Anxiety	☐ Bipolar	☐ Schizophrenia	☐ Drugs	☐ Alcohol
Uncle	☐ None	☐ Depression	☐ Anxiety	☐ Bipolar	☐ Schizophrenia	☐ Drugs	☐ Alcohol

Medical History: ***(please list your medical history)***

☐ No medical conditions

Surgical History: ***(please list your surgical history)***

☐ No surgical history

Allergies: ***(please list any allergies that you have)***

☐ No medical allergies

Have you experienced any of the following illnesses: ***(check all that apply)***

☐ No	☐ Yes	Seizures
☐ No	☐ Yes	Head trauma with loss of consciousness
☐ No	☐ Yes	Coma

Over the last two days have you been experiencing any of the following symptoms: ***(check all that apply)***

Fever	☐ No	☐ Yes	Diarrhea	☐ No	☐ Yes
Dizziness	☐ No	☐ Yes	Constipation	☐ No	☐ Yes
Weight loss	☐ No	☐ Yes	Nausea or vomiting	☐ No	☐ Yes
Weight gain	☐ No	☐ Yes	Stomach pain	☐ No	☐ Yes
Dry eyes	☐ No	☐ Yes	Burning with urination	☐ No	☐ Yes
Tremor	☐ No	☐ Yes	Urinary incontinence	☐ No	☐ Yes
Ear pain	☐ No	☐ Yes	Chronic muscular pain	☐ No	☐ Yes
Ringing in the ears	☐ No	☐ Yes	Joint pain	☐ No	☐ Yes
Sore throat	☐ No	☐ Yes	Hair loss	☐ No	☐ Yes
Difficulty swallowing	☐ No	☐ Yes	Abnormal menses	☐ No	☐ Yes
Cough	☐ No	☐ Yes	Headaches	☐ No	☐ Yes

Pharmacy Information:

Name: _____ Phone Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact: Please list an individual who FAU SHS staff would call in the event of an emergency or if unable to reach you to discuss and important medical matter.

Name: _____ Home Phone: _____ Cellphone: _____

Address: _____ City: _____ State: _____ Zip: _____

The above information is true and correct to the best of my knowledge.

_____ _____

Signature of Student Date

_____ _____

Signature of Provider Date