University of Pittsburgh Student Health Services
Initial Assessment Form

Name: _____

MRN: _____-_____-_____ DOB: ____/_____/_____

Date: _____/_____/_____

Allergies (Describe reaction):

_____
_____
_____

Environmental / Food allergies: _____
_____

Medications:(including birth control pills / supplements.)

_____
_____
_____
_____
_____

Medical History: (C-current / P-past)

√ Check all conditions that apply to you:

C	P	Condition
		Asthma / other respiratory problems
		High Blood Pressure
		Heart Disease
		Irregular Heart Beat
		Anemia
		Abdominal pain/ indigestion
		Liver disease incl. Hepatitis
		Intestinal disease/ disorder
		Musculoskeletal disorder
		Kidney disorder / frequent urinary infections
		Convulsions / seizures / epilepsy
		Migraines
		Sleep disorder
		Mental health (incl. Depression / Anxiety)
		Drug / Alcohol addiction
		Diabetes
		Thyroid disease
		Eating disorder/anorexia/bulimia
		Tuberculosis or positive skin test
		Sexually transmitted disease
		Physical / Sexual assault
		Surgery
		Hospitalization
		Other:

Social History: (C-current / P-past)

√ Check all activities that apply to you:

C	P	Activity	Volume
		Cigarettes/chewing tobacco	___ cigs/day x __yrs ___cans/week
		Smokeless tobacco	Amt. _____
		Alcohol	Avg. drinks / wk_____
		Exercise	# times / wk_____
		Recreational Drugs	Specify:_____
Are you sexually active?			Yes____ No_____
If yes - Partner(s) are			Male__ Fem.__Both__
Do you use condoms?			Yes___No___Occ.___
Do you use seat belts/helmets?			Yes_____ No_____

Family Medical History:

√ Check condition and specify your relationship

	Condition	Relationship
	Heart Disease	
	Hypertension	
	Stroke	
	Diabetes	
	Cancer	
	Obesity	
	Alcohol / Drug addiction	
	Asthma/Lung disease	
	Mental disorder	
	Other (Liver, Kidney, ect..)	

Weight/Dietary History:

Have you gained or lost weight recently?
Yes_____No_____Describe:

Any dietary restrictions?		
Caffeine: _____ Cups of coffee, Tea, pop/day	Calcium:____ # of dairy products/day	Fiber: _____ # of fruit or veg/day

For Men Only:
Do you do self testicular exam? Yes ____No ____

For Women Only:
Age at 1st menses_____#of days between periods_____
Usual # of days bleeding_____
Date of last Pap smear_____#of pregnancies_____
Current method of birth control_____
Do you self breast exam? Yes____No____

CLINICIAN NOTES ↓↓↓ Reviewed By: _____ Review Date: _____/_____/_____

Education/referrals/recommended F/U:

____SBE/STE ____Refer QUIT/Health Ed ____Refer Counseling Center ____Refer dietician
____Safer sex ____Diet/exercise ____Refer other (specify)_____