

UCSF Student Health Service - New Student Intake Form (page 2)

ALLERGIES

Shaded areas for SHS use

Date	ALLERGIC REACTION TO:	Type of reaction	DATE	Init

PERSONAL HEALTH HISTORY

Shaded areas for SHS use

Date	Problem List (past hospital admissions, surgeries, ongoing or recurrent conditions)	DATE	Init

MEDICATIONS

DATE start	MEDICATION / dose / frequency	DATE stop	DATE start	MEDICATION / dose / frequency	DATE stop

Name _____ School _____ Entry date ____ / ____ / ____
Last First Middle (program start date) mo yr