MSJC Mt. San Jacinto College
STUDENT HEALTH CENTER

NEW PATIENT REGISTRATION

Complete This Form **Prior** to Your Visit

First **Name**: ..... Last Name: ..... Date of Birth: ...../...../.....

Preferred Gender: ◯M ◯F **Assigned** Gender at Birth: ◯M ◯F **Phone** #: .....

Email: .....

Mailing **Address**: ..... City/State: ..... ZIP: .....

Marital Status: ..... Emergency **Contact** Name & Phone #: .....

Preferred **Pharmacy** (Name, Address, Phone #):

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Do you have Insurance?: ◯Yes ◯No What insurance **plan type?** ◯HMO ◯PPO ◯EPO ◯ POS ◯ Other .....

PCP Name: .....

1. Do you have any medical conditions? ◯ No, I'm healthy! ◯ Yes (see list)

◯ High **Blood Pressure**
◯ **Diabetes** (A1C:.....)
◯ High **Cholesterol**
◯ **Heart** Disease
◯ **Lungs**/Breathing Issues
◯ **Kidney** Disease
◯ **Substance/Marijuana** Use
◯ **Depression/Anxiety**
◯ **Headaches**
◯ **Sleep** Issues
◯ **Thyroid** Issues
◯ **Joint** Pain
◯ **Gut** Issues
◯ **Suicidal Ideation**
◯ **Anemia**
◯ **Skin** Issues
◯ **Menstrual** Issues
◯ **Menopause** Issues
◯ **Erectile** or **Prostate** issues
◯ **Sexual Assault/Domestic Violence**:
◯ **Other:** (discuss below):

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2. Have you had any **surgeries**? ◯ No ◯ Yes → **What** and **When**?.....
3. Do you take any **medications**? ◯ No ◯ Yes → Please **BRING ALL** the bottles along to your visit
4. Any Medication **Allergies**? ◯ No ◯ Yes → Please **list**: .....
5. Do you **smoke**, vape or chew? ◯ Never ◯ I Quit ◯ Yes → How much? .....
6. Do you **Drink**? ◯ Never ◯ Rarely, socially ◯ Yes ...../day ◯ Recovering alcoholic
7. Do you use **drugs** or non-prescribed pills? ◯ No ◯ Rarely ◯ weekly ◯ Daily
8. Are you **sexually active**? ◯ No ◯ Yes → Would you like to be checked for STDs? ◯ Yes ◯ No
9. Were your **parents** affected by cancer, stroke, or heart attack? ◯ No ◯ Yes: .....
10. Do you see any **specialists**? ◯ No ◯ Yes → for what?.....

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SCREENING EXAMS: In what year was your most recent examination (if applicable):

Colonoscopy (Age >45) ..... PAP Smear (Age >21) ..... Mammogram (Age >40) .....

May we contact you by **phone**, **email**, or **text** to confirm appointments? ◯ Yes ◯ No

May we leave you **voicemails** regarding results, medications, treatments, etc? ◯ Yes ◯ No

May we **discuss** your medical information with any member of your family? ◯ Yes ◯ No

> If YES, please **list names** of the members allowed:

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Print Name: ..... Sign: ..... Date: ...../...../.....