F1 ____ *Health* ____

Santa Monica College – Health Services Virtual Form

Name ________________ ________________ ________ Date ______ Time ______
Last name *First name* *M.I.*

☐ Female ☐ Male ☐ Non-Binary **Are You Pregnant?** ☐ Yes ☐ No ☐ Student ☐ Staff/Other

Student ID ____________ Birth Date ____________ Age ______ Phone ____________

REASON FOR VISIT:

☐ Blood Pressure
☐ Illness/Assess.
☐ Telephone Consult
☐ Insurance Help
☐ Hearing
☐ Vision
☐ Immunizations/Vaccines
☐ First Aid
☐ TB **Test**
☐ TB Read
☐ Medication
☐ Prescheduled
☐ MD/NP Appointment
☐ Condoms
☐ Tampons/Pads
☐ Other

Over the last two weeks, have you been feeling:	***Not at all***	***Several days a week***	***More than half the days***	***Nearly Every Day***
1. Down, depressed, or hopeless	☐	☐	☐	☐
2. Or have little interest in doing things	☐	☐	☐	☐

Are you interested in learning more about food and housing security resources (yes/no)? ____________

I, ________________________
Print name: Last, First

Hereby release SMC Health Services of any liability associated with the administration of medications, venipuncture, and/or treatment.

Medication taken in the last 24 hours ____________

____

Medical allergies ____________

Are you pregnant? ____________

Virtual encounter no ____________

medication given — ____________

Signature ____________ *Age* ____

Administered by ____________ *Date* ______ *Time* ______

I, ________________________
Print name: Last, First

Authorize SMC Health Services to release health information on:

Health History ____________

Physical Exam ____________

Other (specify) ____________

Treatment Refusal ____________

____

Signature ____________

Date ____________

------This section is for Office Use Only-----

Seen by ☐ RN ☐ MD ☐ NP ☐ HA ☐ Ledger ☐ Clinic ☐ ISIS

____

Ref: On Campus ____________ Off Campus ____________ Paid ____________ 02-05-24