



## STUDENT HEALTH SERVICES

1239 Arden Rd., Mail Code 1-8, Pasadena, CA, 91125  
626-395-6393 - Phone 626-585-1522 - Fax

### STUDENT HEALTH FORM 2017-2018 PART 2: MY CALTECH HEALTH PORTAL

To complete the second part of your student health form please follow these instructions. If you have any questions please contact Student Health Services at 626-395-6393 or email [healthforms@caltech.edu](mailto:healthforms@caltech.edu).

1. Go to the student health portal: <https://mycaltechhealth.caltech.edu>
2. Using your access.caltech credentials, log in.
  - a. Your user ID is your Caltech email without “@caltech.edu”

Welcome to Student Health Web Portal | [Logout](#)



Please enter your username and password.

Username:   
Password:

[Proceed](#)

[Cancel](#)

Please login using your university-assigned username and password.  
*Your Health is Our Priority*

3. Enter you date of birth

Welcome, Test Patient8 | [Logout](#)



Welcome back! To confirm your identity, you must provide the following additional personal information:

Please confirm your birth date:

[Proceed](#)

[Cancel](#)

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4. Once you have logged in. Click on FORMS

Welcome, Test Patient8 | [Logout](#)

# Home

You last logged in: 7/12/2017 2:45:12 PM

You have 10 unread secure messages [\[Go to Messages\]](#)

## Welcome to Student Health Services OpenCommunicator

This site is designed to help students interact more conveniently and efficiently with Student Health Services. Using the links at the left you can:

- Update your profile information
- Schedule Health Center appointments online anytime
- Receive instructions on how to book a Counseling visit

5. Click on HEALTH HISTORY FORM

Welcome, Test Patient8 | [Logout](#)

# Entrance Medical Requirements

Name: **Patient8, Test**  
School:  
ID Number: **T008**

Before you begin your studies at The University you must complete certain online requirements, including:

- Consent for Treatment
- Health History Form
- Notice of Privacy Practices
- OT Informed Consent

**Prior to opening these pages to complete your entrance requirements:**

1. **Gather your health records, including medication and immunization records.**
2. **Review your records and your family health history with family members.**

Form Name	Status
Consent for Treatment	✔ <b>Completed:</b> Submitted on: Wednesday, May 24, 2017 1:28 PM
<b>Health History Form</b>	Not Yet Complete: Please provide the requested information with special attention to the required fields.
Notice of Privacy Practices	✔ <b>Completed:</b> Submitted on: Thursday, May 25, 2017 8:57 AM
<a href="#">OT Informed Consent</a>	Not Yet Complete: Please provide the requested information with special attention to the required fields.

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6. Begin completing your “Student Health Services Health History Form”

Welcome, Test Patient8 | [Logout](#)



Health History Form

Student Health Services Health History Form

- Home
- Profile
- Appointments
- Messages
- Forms
- Survey Forms
- Account Summary
- Immunizations

All students must complete this form  
**(ALL INFORMATION IS CONFIDENTIAL)**

**Personal Medical History**

**Personal Health History:**  
 If you have no past or current **personal** medical problems, please mark the appropriate starred \* box under each category. A pop up will appear and ask for an approximate date or age of onset. You will be forced to enter something. Feel free to simply enter "from birth". An exact date is NOT required.

<p><b>Medical History</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> **No medical problems</li> <li><input type="checkbox"/> Allergic Rhinitis</li> <li><input type="checkbox"/> Asthma</li> <li><input type="checkbox"/> Autoimmune disorders</li> <li><input type="checkbox"/> Back pain</li> <li><input type="checkbox"/> Blood disorders/Anemia</li> <li><input type="checkbox"/> Cancer</li> <li><input type="checkbox"/> Diabetes, Type I</li> <li><input type="checkbox"/> Diabetes, Type II</li> <li><input type="checkbox"/> Eye problems</li> <li><input type="checkbox"/> Gastrointestinal problem(s)</li> <li><input type="checkbox"/> Head injury with unconsciousness</li> <li><input type="checkbox"/> Hearing problem</li> <li><input type="checkbox"/> Heart disease</li> <li><input type="checkbox"/> Hepatitis B disease</li> <li><input type="checkbox"/> Hepatitis C disease</li> <li><input type="checkbox"/> HIV positive</li> <li><input type="checkbox"/> Hyperlipidemia</li> <li><input type="checkbox"/> Musculoskeletal Problems</li> </ul>	<p><b>Medical History, cont'd</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Kidney disease</li> <li><input type="checkbox"/> Learning disability</li> <li><input type="checkbox"/> Migraine headaches</li> <li><input type="checkbox"/> Mobility limitations</li> <li><input type="checkbox"/> Neurologic problem(s)</li> <li><input type="checkbox"/> Seizure disorder</li> <li><input type="checkbox"/> Sexually transmitted infections</li> <li><input type="checkbox"/> Thyroid problem(s)</li> <li><input type="checkbox"/> Vision problem(s)</li> </ul> <p><b>Mental Health</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> **No mental health problems</li> <li><input type="checkbox"/> Anxiety disorder</li> <li><input type="checkbox"/> Bipolar disorder</li> <li><input type="checkbox"/> Depression</li> <li><input type="checkbox"/> Eating disorder</li> <li><input type="checkbox"/> Psychosis/ Schizophrenia</li> <li><input type="checkbox"/> Sleep problem(s)</li> </ul>	<p><b>Social History</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Alcohol use</li> <li><input type="checkbox"/> Exercise</li> <li><input type="checkbox"/> Illegal drug or substance use</li> <li><input type="checkbox"/> Smoking/ Tobacco use</li> </ul> <p><b>Women's Health</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> **No women's health problems</li> <li><input type="checkbox"/> Abnormal Pap Smear</li> <li><input type="checkbox"/> Absent periods</li> <li><input type="checkbox"/> Contraceptive Use</li> <li><input type="checkbox"/> Irregular periods</li> <li><input type="checkbox"/> Pelvic pain</li> <li><input type="checkbox"/> Severe menstrual pain</li> </ul>
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Additional personal history comments, if needed:

**Family Medical History**

**Family History:**  
 If you do not know, or if you have no past or current **family** medical problems, please mark one of the first starred \* boxes. A pop up will appear and ask for an approximate date or age of onset. You will be forced to enter something. Feel free to simply enter "from birth". An exact date is NOT required.

<p><b>Family History</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> **Family medical history unknown</li> <li><input type="checkbox"/> **Family mental health history not known</li> <li><input type="checkbox"/> Hereditary disorders</li> </ul>	<p><b>Medical History</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> **No medical problems</li> <li><input type="checkbox"/> Asthma</li> <li><input type="checkbox"/> Cancer</li> <li><input type="checkbox"/> Diabetes, Type I</li> </ul>	<p><b>Mental Health</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> **No mental health problems</li> <li><input type="checkbox"/> Anxiety disorder</li> <li><input type="checkbox"/> Bipolar disorder</li> <li><input type="checkbox"/> Depression</li> </ul>
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