UF Student Health Care Center Health History Questionnaire

Name: _____ Sex: -- Date of Birth: _____

UF ID: _____ SSN: _____ UF E-mail Address: _____

Perm. Address: _____ Local Address: _____

_____ Zip: _____ _____ Zip: _____

Perm. Phone: (_____) _____ Local Phone: (_____) _____

In case of an emergency, notify: _____ _____

Full name Relationship

_____ (_____) _____

Full address with zip code Telephone including area code

Medical History:

1. Do you have any **allergies** to the following:

Medicines/Drugs: No ____ Yes (list) _____

Foods: No ____ Yes (list) _____ Environmental: No ____ Yes (list) _____

2. List any **hospitalizations and/or surgeries** you have had, including the type and date:

_____ _____

_____ _____

3. List all **prescription and non-prescription medications** you take regularly or daily (including birth control pills). Please list dosages for each.

_____ _____

_____ _____

_____ _____

4. Please indicate **your personal and social histories** of the following (check "yes" or "no" for each item listed; note additional information as needed):

	Currently		Past Problems		Comments
	Yes	No	Yes	Date(s)	
Arthritis or Joint Injuries					
Asthma					
Blood Abnormalities (list type)					
Cancer or Hepatitis (list type)					
Diabetes or Thyroid Disease					
Ears, Nose or Throat Problems					
Eye Problems					
Fever, Weight Gain or Loss					
Gastrointestinal					
Gynecological					
Heart Disease or High Blood Pressure					
Psychological/Emotional					
Rashes					
Seizures/Epilepsy					
Urinary Problems					
Other (list)					
Alcohol/Substance Abuse					
Tobacco Use (list type/amount)					

5. Please indicate **your immediate family's—mother, father, sibling(s)—history** of the following (check "yes" or "no" for each item listed; note additional information as needed):

	Yes	No	Family Member	Comments
Arthritis or Joint Injuries				
Asthma				
Blood Abnormalities (list type)				
Cancer or Hepatitis (list type)				
Cholesterol/Lipid Disorder				
Diabetes or Thyroid Disease				
Heart Disease or High Blood Pressure				
Other (list)				
Alcohol/Substance Abuse				

Permission for Diagnosis and Treatment Procedures:

I hereby authorize the health care providers of the University of Florida Student Health Care Center (SHCC), their agents or consultants, to perform diagnostic and treatment procedures that, in their judgment, may become necessary while at the University of Florida. I understand that I am responsible for further charges incurred and authorize the University Faculty Group Practice and Student Health Care Center to release medical information necessary to process medical claims. I authorize release of any information to county, state or federal public health agencies, as required by law.

Patient Signature: _____ Date: _____ SHCC OFFICE USE ONLY SHCC Medical Provider Signature: _____ Date: _____

IF PATIENT IS A MINOR/UNDER THE AGE OF 18, PLEASE COMPLETE THE FOLLOWING:

Legal Representative Signature: _____ Date: _____ Witness Signature: _____ Date: _____

Printed Legal Rep. Name/Relationship: _____ -- Printed Witness Name: _____