Health History – Medical Information

Student Health Care Center – University of Florida

Thank you for choosing the UF Student Health Care Center (SHCC) for your healthcare needs. Remember: We are here to help! The information you provide on this form is strictly confidential. The SHCC collects this information in order to provide comprehensive care.

OFFICE USE ONLY

MEDICAL HISTORY

MEDICATIONS: LIST PRESCRIPTIONS, OVER-THE-COUNTER MEDS, VITAMINS & SUPPLEMENTS.

MEDICATION NAME – OR WRITE "NONE":	DOSAGE & FREQUENCY:
___	___
___	___
___	___
___	___
___	___

DRUG ALLERGIES: LIST ALL PERTINENT INFORMATION.

DRUG NAME – OR WRITE "NONE":	REACTION:
___	___
___	___
___	___
___	___
___	___

PERSONAL HISTORY & REVIEW OF SYSTEMS: CHECK YES OR NO – ELABORATE AS NEEDED.

CONDITION:	CURRENT YES	CURRENT NO	PAST (DATES ONLY)	CONDITION:	CURRENT YES	CURRENT NO	PAST (DATES ONLY)
ALLERGIES* (*ENVIRONMENTAL, FOOD, OTHER*)				HEART DISEASE			
ASTHMA				HEPATITIS			
BLOOD DISORDERS (*ANEMIA, CLOTS, SICKLE CELL, OTHER*)				HIGH BLOOD PRESSURE/HYPERTENSION			
CANCER – LIST TYPE(S) HERE:				PSYCHOLOGICAL (*ANXIETY, DEPRESSION, OTHER*)			
CHOLESTEROL/LIPID DISORDER				SEIZURES/EPILEPSY			
DIABETES (*PRE-DIABETES, TYPE I, TYPE II*)				SKIN DISORDERS (*ACNE, ECZEMA, RASH, WARTS, OTHER*)			
EAR, NOSE OR THROAT (*HEARING, OTHER*)				SLEEP PROBLEMS (*FATIGUE, INSOMNIA, OTHER*)			
EATING DISORDER(S) (*BINGING, PURGING, BODY IMAGE, OTHER*)				THYROID DISEASE			
EYE PROBLEMS (*GLASSES, CATARACTS, OTHER*)				URINARY PROBLEMS (*BLADDER INFECTIONS, UTI, OTHER*)			
GASTROINTESTINAL (*CONSTIPATION, ULCERS, OTHER*)				WEIGHT GAIN/LOSS			
HEADACHES OR MIGRAINES							

***IF NEEDED, PLEASE ELABORATE ON ANY ANSWERS ABOVE:**

OTHER ISSUE(S) – LIST ALL RELATED INFORMATION:

ADDITIONAL INFORMATION: CHECK THE MOST APPROPRIATE BOXES.

IN THE PAST 2 WEEKS, HOW OFTEN HAVE YOU:

- FELT LITTLE INTEREST OR PLEASURE IN DOING THINGS: ☐ NOT AT ALL ☐ SEVERAL DAYS ☐ MORE THAN HALF THE DAYS ☐ NEARLY EVERY DAY
- FELT DOWN, DEPRESSED OR HOPELESS: ☐ NOT AT ALL ☐ SEVERAL DAYS ☐ MORE THAN HALF THE DAYS ☐ NEARLY EVERY DAY

HOSPITALIZATION(S) AND/OR SURGERY(IES): LIST SURGERY TYPE(S) AND DATE(S).

SOCIAL HISTORY: CHECK YES OR NO – ELABORATE AS NEEDED.

CONDITION:	CURRENT YES	CURRENT NO	PAST (DATES ONLY)	CONDITION:	CURRENT YES	CURRENT NO	PAST (DATES ONLY)
TOBACCO USE (*CIGARETTES, DIP/CHEW, HOOKAH, OTHER*)				ALCOHOL USE			
ELECTRONIC CIGARETTE/VAPOR PEN USE				SUBSTANCE USE (*MARIJUANA, PILLS, OTHER*)			

IF NEEDED, PLEASE ELABORATE ON ANY ANSWERS ABOVE:

IMMEDIATE FAMILY HISTORY (MOTHER, FATHER OR SIBLINGS): CHECK YES OR NO – ELABORATE AS NEEDED.

CONDITION:	YES	NO	FAMILY MEMBER	CONDITION:	YES	NO	FAMILY MEMBER
ALCOHOL OR SUBSTANCE ABUSE				DIABETES (*PRE-DIABETES, TYPE I, TYPE II*)			
ASTHMA				HEPATITIS			
BLOOD DISORDERS (*ANEMIA, CLOTS, SICKLE CELL, OTHER*)				PSYCHOLOGICAL (*ANXIETY, DEPRESSION, OTHER*)			
CANCER – LIST TYPE(S) HERE:				THYROID DISEASE			
CARDIOVASCULAR (*CHOLESTEROL, HEART DISEASE, HYPERTENSION*)				OTHER – LIST HERE:			

IF NEEDED, PLEASE ELABORATE ON ANY ANSWERS ABOVE:

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Health History – Sexual Health & GYN Information
Student Health Care Center – University of Florida

PLEASE NOTE: This page of the Health History is recommended but not required. Information provided here can help your healthcare provider make recommendations for additional health and wellness services; however, **if you do not wish to address any of the following health topics today, please draw an "X" over this page.**

OFFICE USE ONLY

SEXUAL HEALTH HISTORY

SEX ASSIGNED AT BIRTH: ☐ MALE ☐ FEMALE

GENDER IDENTITY: ☐ MALE ☐ FEMALE ☐ ______

SEXUALLY ACTIVE IN THE PAST 12 MONTHS: ☐ YES ☐ NO

IF NO: SEXUALLY ACTIVE IN THE PAST: ☐ NO ☐ YES

IF SEXUALLY ACTIVE, NOW OR IN THE PAST:
- MY PARTNER(S) HAVE INCLUDED: ☐ OPPOSITE SEX* ☐ SAME SEX* ☐ BOTH
  *SEX ASSIGNED AT BIRTH
- TOTAL NUMBER OF PARTNER(S), PAST 12 MONTHS: ______

CURRENT METHOD(S) OF SEXUAL TRANSMITTED INFECTION PREVENTION AND/OR BIRTH CONTROL: ______

SATISFIED WITH METHOD(S): ☐ YES ☐ NO – SPECIFY: ______

CHECK YES OR NO – ELABORATE AS NEEDED.
- HPV VACCINE (GARDASIL OR CERVARIX): ☐ NO ☐ YES ☐ NOT SURE
- HISTORY OF SEXUAL TRANSMITTED INFECTION: ☐ NO ☐ YES – SPECIFY: ______
- SEXUAL CONCERNS: ☐ NO ☐ YES – SPECIFY: ______
- PAINFUL INTERCOURSE: ☐ NO ☐ YES– SPECIFY: ______

HISTORY OF EMOTIONAL, PHYSICAL OR SEXUAL ABUSE AND/OR SEXUAL ASSAULT: ☐ NO ☐ YES – COMMENTS OPTIONAL: ______

______

IF APPLICABLE – GYNECOLOGICAL HEALTH HISTORY

OBTAIN REGULAR GYNECOLOGICAL CARE	LAST PELVIC EXAM (MM/DD/YYYY)	LAST PAP SMEAR (MM/DD/YYYY)
☐ YES ☐ NO	___ ___ / ___ ___ / ___ ___ ___ ___	___ ___ / ___ ___ / ___ ___ ___ ___
HISTORY OF ABNORMAL PAP	*IF YES TO ABNORMAL PAP:* DATE (MM/DD/YYYY)	*IF YES TO ABNORMAL PAP:* SPECIFY FOLLOW-UP.
☐ YES ☐ NO	___ ___ / ___ ___ / ___ ___ ___ ___	

CHECK YES OR NO – ELABORATE AS NEEDED.
- FREQUENT BLADDER INFECTIONS: ☐ NO ☐ YES – SPECIFY: ______
- FREQUENT VAGINAL INFECTIONS: ☐ NO ☐ YES – SPECIFY: ______
- OVARIAN CYST(S): ☐ NO ☐ YES – SPECIFY: ______
- BREAST PROBLEMS OR SURGERY: ☐ NO ☐ YES – SPECIFY: ______
- GYNECOLOGICAL SURGERY: ☐ NO ☐ YES – SPECIFY: ______

IF APPLICABLE - MAMMOGRAM AND/OR ULTRASOUND: INDICATE DATE(S) AND FINDINGS. ______

IF APPLICABLE – MENSTRUAL HISTORY

FIRST DAY OF LAST MENSTRUAL PERIOD (MM/DD/YYYY)	WAS IT NORMAL FOR YOU?	AGE (IN YEARS) AT FIRST MENSTRUAL PERIOD
___ ___ / ___ ___ / ___ ___ ___ ___	☐ YES ☐ NO ______	
PROBLEMS WITH PERIOD NOW (EX: BAD CRAMPING, PMS, ETC.)	PROBLEMS WITH PERIOD IN THE PAST	HOW OFTEN DO YOU GET YOUR PERIOD?
☐ NO ☐ YES– SPECIFY: ______	☐ NO ☐ YES ______	
LENGTH OF YOUR PERIOD	FLOW (CIRCLE ONE): LIGHT MEDIUM HEAVY VERY HEAVY OTHER – DESCRIBE: ______	

IF APPLICABLE – PREGNANCY & BIRTH (OBSTETRICAL) HISTORY

PREGNANCY(IES): PLEASE INDICATE THE FOLLOWING: ____# LIVING CHILDREN ____# FULL-TERM BIRTHS ____# PRE-TERM BIRTHS ____# SPONTANEOUS MISCARRIAGE / ELECTIVE ABORTION

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Health History – General Information

Student Health Care Center – University of Florida

OFFICE USE ONLY

PATIENT/STUDENT INFORMATION

PATIENT/STUDENT NAME (LAST, FIRST, MIDDLE INITIAL)	OTHER NAMES/ALIASES, PREFERRED PRONOUNS		UF ID NUMBER
LOCAL STREET ADDRESS	CITY, STATE	ZIP CODE	CELL PHONE, INCLUDING AREA CODE
PERMANENT STREET ADDRESS – IF APPLICABLE	CITY, STATE	ZIP CODE	OTHER PHONE, INCLUDING AREA CODE

BIRTH DATE (MM/DD/YYYY)	SEX ASSIGNED AT BIRTH	GENDER IDENTITY	PRIMARY LANGUAGE – *TRANSLATOR NEEDED?* ☐ NO ☐ YES
___ ___ / ___ ___ / ___ ___ ___ ___	☐ MALE ☐ FEMALE	☐ MALE ☐ FEMALE ☐ ______________	

MARITAL STATUS: ☐ SINGLE ☐ SIGNIFICANT OTHER ☐ LIFE PARTNER ☐ MARRIED ☐ LEGALLY SEPARATED ☐ DIVORCED ☐ WIDOWED ☐ OTHER ☐ UNKNOWN

ETHNICITY: ☐ HISPANIC/LATINO(A) ☐ NOT HISPANIC/LATINO(A) ☐ UNKNOWN ☐ DECLINE

RACE: ☐ AMERICAN INDIAN/ALASKA NATIVE ☐ ASIAN ☐ BLACK/AFRICAN AMERICAN ☐ NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER ☐ WHITE ☐ OTHER ☐ UNKNOWN ☐ DECLINE

HEALTH INSURANCE INFORMATION

If you have not already done so, please provide your current insurance card to the secretary, as well as any updates to your coverage. If you do not have your card with you, email (verify@shcc.ufl.edu) or fax (352-392-7620) a copy of the front and back of the card to SHCC Patient Financial Services ASAP after your visit. **QUESTIONS? Contact SHCC Patient Financial Services via email (insurance@shcc.ufl.edu) or phone (352-273-4546).**

OTHER HEALTHCARE PROVIDER YOU SEE ON A REGULAR BASIS (PRIMARY CARE PROVIDER)

NAME	TYPE OF HEALTHCARE PROVIDER		BUSINESS PHONE, INCLUDING AREA CODE
STREET ADDRESS	CITY, STATE	ZIP CODE	DATE(S) OF CARE

PERMISSION FOR DIAGNOSIS & TREATMENT PROCEDURES

I hereby authorize the healthcare providers of the University of Florida (UF) Student Health Care Center (SHCC), their agents or consultants, to perform diagnostic and treatment procedures that, in their judgment, may become necessary while at UF. I understand that I am responsible for further charges incurred and authorize the University Faculty Group Practice and SHCC 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. **Parental consent for diagnosis and treatment is required for patients under the age of 18.**

NOTE: If you would like to communicate with a third party about your current condition(s), please give your healthcare provider contact information and verbal permission. **In the event of an emergency, Emergency Contact information will be obtained from the Office of the University Registrar.**

PATIENT NAME - PRINTED	PATIENT SIGNATURE	DATE
FOR OFFICE USE ONLY: PROVIDER NAME - PRINTED	*PROVIDER SIGNATURE*	*DATE*

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