UFHealth
UNIVERSITY OF FLORIDA HEALTH

PATIENT HISTORY QUESTIONNAIRE

Name: DOB: DATE: Male/Female

Instructions: Please fill out the form, print it and bring to your next appointment. Note that your health information is private and will be stored in a secured electronic medical record.

I. Medications (Please list all of your current medications including prescriptions, over-the-counter medications and vitamins and how often you take them)

II. Allergies (Please list allergic/adverse reaction to medication/food/latex gloves/eggs/dyes and reactions you have)

III. Previous Hospitalizations (Please list all previous hospitalizations including the reason and the date)

Previous Surgical History (Please list all surgeries and the date)

Last revised: November 7, 2013 by Rich Koerner, 244-5010

PATIENT HISTORY QUESTIONNAIRE (Cont'd)

Check All That Apply To You

History of:

	Yes	No		Yes	No
Heart Attack			Frequent Bladder Infections		
Angina			Bladder Incontinence		
High Blood Pressure			Headaches		
High Cholesterol			Seizures		
Heart Valve Disease			Stroke		
Congestive Heart Failure			Diabetes		
Rheumatic Fever			Thyroid Problems		
Asthma			Anemia		
Emphysema			Blood Clots		
Positive TB Test			Sickle Cell		
Stomach Ulcers			Easy Bruisibility/Prolonged Bleeding		
Reflux/Hiatal Hernia			Depression		
Colon Polyps			Anxiety Disorder		
Hepatitis/Jaundice			Alcohol/Drinking Problem		
Gallbladder Disease			Drug Dependence		
Kidney Stones			Back Injury		
Arthritis			Bone/Joint Injury		
Cancer			Glaucoma		
Sexual or Physical Abuse			Excessive Snoring		
Insomnia			Hearing loss		
Vision loss			Wear glasses		
Mental Illness			Other		

IV. Family History

Please check significant medical conditions among your BLOOD relatives

	Yes	No		Yes	No
Asthma			Arthritis		
Diabetes			Heart Attack		
High Blood Pressure			High Cholesterol		
Stroke					
Cancer			Type of Cancer _____		
Blood Disorder			Sickle Cell Anemia		
Kidney Disease			Liver Disease		
Colon Disease			Glaucoma		
Cataracts			Depression		
Mental Illness			Alcoholism		
Drug Dependence/Abuse			Anxiety Disorder		
Other					

V. Health Maintenance/Preventative Healthcare

Colon Screening
Have you had a colonoscopy ☐ Yes ☐ No Date _____
Abnormal ☐ Yes ☐ No
Polyps ☐ Yes ☐ No

Cholesterol Screening
Date of Last Cholesterol Check _____
Abnormal ☐ Yes ☐ No
Date of Last Diabetes Check _____

Immunizations/Tests for Adults
Flu Vaccine
Pneumovax
Tetanus/Diphtheria/Pertussis
Hepatitis B Vaccine
Zostervax (shingles)

Immunizations/Tests for Children/Adolescents
Immunizations up to date? **Please bring shot record(s).**

Do you have a living will ☐ Yes ☐ No
Do you have a health surrogate ☐ Yes ☐ No

Women
Date of Last Mammogram
History of Abnormal Mammogram ☐ Yes ☐ No
Date of Last Pap Smear
History of Abnormal Pap ☐ Yes ☐ No
Date of Last Bone Density
Number of pregnancies _____Number of Deliveries _____
Age of starting menstrual period _____
Age of ending menstrual period _____
Menstrual Cycle –How often _____How long _____Flow _____Date of Last Period _____

Men
Date of Last Prostate Exam
History of Abnormal Prostate Exam ☐ Yes ☐ No
Date of Last PSA
History of Abnormal PSA ☐ Yes ☐ No

PATIENT HISTORY QUESTIONNAIRE (Cont'd)

VI. Social History

Cigarette Use ☐ Never ☐ Quit _____Date
If you are a smoker how many packs/day _____
How long have you smoked _____
Do you smoke ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chewing Tobacco

Alcohol Usage
Do you drink alcohol ☐ Yes ☐ No
Number of drinks/week _____
Alcohol problems in the past ☐ Yes ☐ No

Drug Use
Do you use any recreational or illegal drugs ☐ Yes ☐ No
Have you ever used needles to inject drugs ☐ Yes ☐ No

Sexual History
Are you sexually active ☐ Yes ☐ No
Current Sex Partner ☐ Male ☐ Female
Birth Control Method_____
Have you ever had a sexually transmitted disease ☐ Yes ☐ No

Socio-Economic History
What is your occupation?
Years of Education/Highest Degree
Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Who lives with you at home?
What language is spoken at home _____

Nutritional Habits
Would you describe your current diet as healthy? Yes____ No_____
How many meals and snacks do you eat daily? Meals ____ Snacks ____

Physical Activity
Do you engage in any form of regular physical activity (at least 3 days per week)
Yes ____ No_____

VII. For Patients With Diabetes

Date of Last A1C Result
Date of Last Urine Microalbumin
Date of Last Eye Exam
Do you regularly test Blood Sugars at home ☐ Yes ☐ No

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