UCF Health
COLLEGE OF MEDICINE PRACTICE

Patient Name: ______________________________

Date of Birth: ______________________________

HEALTH HISTORY QUESTIONNAIRE

Primary Care Physician: ______________________________

Other physicians you currently see: ______________________________

Emergency Phone #:____________________Contact Person/Relationship: ____________________

Reason for the Visit: ______________________________

Please list your medications and respective dosages in the chart below and provide the reason why you take it.
Please list all vitamins, over the counter medications, herbal medicine, etc.

Medication	Dose (units or mg)	Frequency	Reason/Prescribed Date

Preferred Pharmacy
Name:______________________________
Address:______________________________Zip Code:____________________

Chronic Medical Problem List	Date Diagnosed	Chronic Medical Problem List	Date Diagnosed

Allergies	
Substance or Medication	Reaction

Patient Name: ________________________________ Date of Birth: _____________________________

Past Surgical History

Procedures | Surgeries | Hospitalization	Date

Family History

Yes	No	Condition	Family Member(s)
☐	☐	Alzheimer's / Dementia	
☐	☐	Breast Cancer	
☐	☐	Colon Cancer	
☐	☐	Depression	
☐	☐	Diabetes	
☐	☐	Elevated Cholesterol	
☐	☐	Heart Disease/Stroke	
☐	☐	High Blood Pressure	
☐	☐	Ovarian/Prostate Cancer	
☐	☐	Skin Cancer	
☐	☐	Thyroid Disease	
☐	☐	Other	

Preventative Health Screening

Screening	Date
Last Colonoscopy	
Last Mammogram	
Last Pap Smear	
Bone Density/DEXA	

Do you have an Advance Directive? ☐ No
☐ Yes *Date*: ___________

If No, would you like to receive information? ☐ Yes ☐No

Social History

Alcohol: ☐ Never
☐ Current
☐ Past

For Current or Past use: ☐ Beer ☐ Wine ☐ Hard Liquor

Amount/Day:_____________Number of years:_________

Tobacco (cigarettes, chewing, etc.): ☐ Never
☐ Current ☐ Past - *Year Quit*_____________

For Current or Past use:

Amount/Day:____________Number of years:_________

Employment: ☐ Currently ☐ Disabled ☐ Part time
☐ Retired ☐ Student ☐ Unemployed ☐ Other

Occupation: _____________

Education: ☐ High School ☐ College ☐ ___________

Marital Status: ☐ Single ☐ Married ☐ Life Partner
☐ Separated ☐ Divorced ☐ Widowed

Exercise: ☐ No
☐ Yes Times per week: __________
Duration (average number of minutes):__________

Vaccination History

Vaccine	Date
Influenza (Flu Shot)	
Tetanus (Td/Tdap)	
Shingles (Zostavax)	
Pneumonia	
Hepatitis B series	
Meningitis	
HPV/Gardasil series	
Other	

I certify that my *Health History Questionnaire* is accurate. I further certify that I have read and agree to the *Patient Policies and Procedures & Notice of Privacy Practices* (rev. 122009.01) located at **UCF Health Website (www.ucfhealth.com/privacy)** including:
1) *Payment and Billing Policy & Procedures*;
2) Disclosure of Information for Reimbursement & Assignment of Benefits; 3) *Notice of Privacy Practices (HIPAA)*

______________________________________ ______________________

Patient Signature *(or caregiver/ parent/guardian if minor)* **Date**

If signed by the Patient's Representative, please print name and describe relationship to patient or other authority to act:

______________________________________ ______________________

Name Relationship to Patient