UFHealth
UNIVERSITY OF FLORIDA HEALTH

UF HEALTH REHAB CENTER AT THE STUDENT HEALTH CARE CENTER

Medical History Intake Questionnaire

Name:____________________________ DOB: ________ /________ / __________ Age: ________

Medical History: Check (x) the box next to any illness that applies to YOU:

- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Aspiration (swallowing difficulties)
- ☐ Asthma
- ☐ Blood transfusion
- ☐ Cancer
- ☐ Cataracts
- ☐ Congestive heart failure
- ☐ Clotting disorder
- ☐ COPD
- ☐ Depression
- ☐ Diabetes mellitus
- ☐ Diarrhea / constipation
- ☐ Emphysema
- ☐ Falls
- ☐ GERD (reflux)
- ☐ Glaucoma
- ☐ Heart attack
- ☐ Heart murmur
- ☐ Hernia
- ☐ HIV/AIDS
- ☐ Hyperlipidemia
- ☐ Meningitis
- ☐ Nerve / muscle disease
- ☐ Osteoporosis
- ☐ Rash/eczema
- ☐ Respiratory problems
- ☐ Seizures
- ☐ Sickle cell
- ☐ Stroke
- ☐ Substance abuse
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Vision problem
- ☐ Anesthetic complications

Other:____

Surgical History: Check (x) the box next to any surgical procedures YOU have had:

- ☐ Adenoidectomy
- ☐ Appendectomy
- ☐ Brain surgery
- ☐ CABG
- ☐ Colon surgery
- ☐ Cosmetic surgery
- ☐ C-section
- ☐ Ear tubes
- ☐ Eye surgery
- ☐ Fracture surgery
- ☐ G-tube placement
- ☐ Gall bladder Surgery
- ☐ Hernia repair
- ☐ Hysterectomy
- ☐ Joint replacement
- ☐ Prostate surgery
- ☐ Shunt
- ☐ Small intestine surgery
- ☐ Spine Surgery
- ☐ Tongue tie clipped
- ☐ Tonsillectomy
- ☐ Tracheotomy
- ☐ Tubal ligation
- ☐ Valve replacement
- ☐ Vasectomy

Other surgeries:____________________________________

Allergies: Check (x) the box next to any allergies YOU have:

- ☐ Penicillin
- ☐ Sulfa
- ☐ Latex

Other:____

Medications: Please elaborate about any medications YOU are currently taking:

Name of drug:	When started:	Name of drug:	When started:

Pain: For the current condition you are being seen for, rate your pain from 0 (none) to 10 (worst imaginable).

Pain now__________ ; Worst pain __________

Do Not File In Medical Record After Discharge