

Health History – Medical Information

Student Health Care Center – Santa Fe College

OFFICE USE ONLY

Thank you for choosing the Student Health Care Center (SHCC) at Santa Fe College 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.

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

CONDITION: CHECK YES OR NO – CIRCLE CHOICE IF INCLUDED.	CURRENT		PAST (DATES ONLY)	CONDITION: CHECK YES OR NO – CIRCLE CHOICE IF INCLUDED.	CURRENT		PAST (DATES ONLY)
	YES	NO			YES	NO	
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							

*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

CONDITION: CHECK YES OR NO – CIRCLE CHOICE IF INCLUDED.	CURRENT		PAST (DATES ONLY)	CONDITION: CHECK YES OR NO – CIRCLE CHOICE IF INCLUDED.	CURRENT		PAST (DATES ONLY)
	YES	NO			YES	NO	
TOBACCO USE: CIGARETTES, DIP/CHEW, HOOKAH, OTHER				ALCOHOL USE			
ELECTRONIC CIGARETTE/VAPOR PEN USE				SUBSTANCE USE: MARIJUANA, PILLS, OTHER			

PLEASE ELABORATE ON ANY ANSWERS ABOVE:

IMMEDIATE FAMILY HISTORY (MOTHER, FATHER OR SIBLINGS)

CONDITION: CHECK YES OR NO—CIRCLE CHOICE IF INCLUDED.			FAMILY MEMBER	CONDITION: CHECK YES OR NO—CIRCLE CHOICE IF INCLUDED.			FAMILY MEMBER
	YES	NO			YES	NO	
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:			
PLEASE ELABORATE ON ANY ANSWERS ABOVE:							

Health History – Sexual Health & GYN Information

Student Health Care Center – Santa Fe College

OFFICE USE ONLY

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.**

SEXUAL HEALTH HISTORY

SEX ASSIGNED AT BIRTH: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	GENDER IDENTITY: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> _____	
SEXUALLY ACTIVE IN THE PAST 12 MONTHS: <input type="checkbox"/> YES <input type="checkbox"/> NO	IF NO: SEXUALLY ACTIVE IN THE PAST: <input type="checkbox"/> NO <input type="checkbox"/> YES	
IF SEXUALLY ACTIVE, NOW OR IN THE PAST: ■ MY PARTNER(S) HAVE INCLUDED: <input type="checkbox"/> OPPOSITE SEX* <input type="checkbox"/> SAME SEX* <input type="checkbox"/> BOTH <small>*SEX ASSIGNED AT BIRTH</small> ■ TOTAL NUMBER OF PARTNER(S), PAST 12 MONTHS: _____	CURRENT METHOD(S) OF SEXUAL TRANSMITTED INFECTION PREVENTION AND/OR BIRTH CONTROL: _____ SATISFIED WITH METHOD(S): <input type="checkbox"/> YES <input type="checkbox"/> NO – SPECIFY: _____	
CHECK YES OR NO – ELABORATE AS NEEDED. ■ HPV VACCINE (GARDASIL OR CERVARIX): <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NOT SURE ■ HISTORY OF SEXUAL TRANSMITTED INFECTION: <input type="checkbox"/> NO <input type="checkbox"/> YES – SPECIFY: _____ ■ SEXUAL CONCERNS: <input type="checkbox"/> NO <input type="checkbox"/> YES – SPECIFY: _____ ■ PAINFUL INTERCOURSE: <input type="checkbox"/> NO <input type="checkbox"/> YES – SPECIFY: _____		
HISTORY OF EMOTIONAL, PHYSICAL OR SEXUAL ABUSE AND/OR SEXUAL ASSAULT: <input type="checkbox"/> NO <input type="checkbox"/> YES – COMMENTS OPTIONAL: _____ _____		

IF APPLICABLE – GYNECOLOGICAL HEALTH HISTORY

OBTAIN REGULAR GYNECOLOGICAL CARE <input type="checkbox"/> YES <input type="checkbox"/> NO	LAST PELVIC EXAM (MM/DD/YYYY) ____/____/____	LAST PAP SMEAR (MM/DD/YYYY) ____/____/____
HISTORY OF ABNORMAL PAP <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES TO ABNORMAL PAP: DATE (MM/DD/YYYY) ____/____/____	IF YES TO ABNORMAL PAP: SPECIFY FOLLOW-UP. _____
CHECK YES OR NO – ELABORATE AS NEEDED. ■ FREQUENT BLADDER INFECTIONS: <input type="checkbox"/> NO <input type="checkbox"/> YES – SPECIFY: _____ ■ FREQUENT VAGINAL INFECTIONS: <input type="checkbox"/> NO <input type="checkbox"/> YES – SPECIFY: _____ ■ OVARIAN CYST(S): <input type="checkbox"/> NO <input type="checkbox"/> YES – SPECIFY: _____ ■ BREAST PROBLEMS OR SURGERY: <input type="checkbox"/> NO <input type="checkbox"/> YES – SPECIFY: _____ ■ GYNECOLOGICAL SURGERY: <input type="checkbox"/> NO <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO _____	AGE (IN YEARS) AT FIRST MENSTRUAL PERIOD _____
PROBLEMS WITH PERIOD NOW (EX: BAD CRAMPING, PMS, ETC.) <input type="checkbox"/> NO <input type="checkbox"/> YES – SPECIFY: _____	PROBLEMS WITH PERIOD IN THE PAST <input type="checkbox"/> NO <input type="checkbox"/> YES _____	HOW OFTEN DO YOU GET YOUR PERIOD? _____
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

Health History – General Information

Student Health Care Center – Santa Fe College

OFFICE USE ONLY

PATIENT/STUDENT INFORMATION			
PATIENT/STUDENT NAME (LAST, FIRST, MIDDLE INITIAL)		OTHER NAMES/ALIASES, PREFERRED PRONOUNS	SFC ID NUMBER
LOCAL STREET ADDRESS		CITY, STATE	ZIP CODE
PERMANENT STREET ADDRESS – IF APPLICABLE		CITY, STATE	ZIP CODE
BIRTH DATE (MM/DD/YYYY) ____/____/____	SEX ASSIGNED AT BIRTH <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	GENDER IDENTITY <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> _____	PRIMARY LANGUAGE – TRANSLATOR NEEDED? <input type="checkbox"/> NO <input type="checkbox"/> YES
MARITAL STATUS: <input type="checkbox"/> SINGLE <input type="checkbox"/> SIGNIFICANT OTHER <input type="checkbox"/> LIFE PARTNER <input type="checkbox"/> MARRIED <input type="checkbox"/> LEGALLY SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/> OTHER <input type="checkbox"/> UNKNOWN			
ETHNICITY: <input type="checkbox"/> HISPANIC/LATINO(A) <input type="checkbox"/> NOT HISPANIC/LATINO(A) <input type="checkbox"/> UNKNOWN <input type="checkbox"/> DECLINE			
RACE: <input type="checkbox"/> AMERICAN INDIAN/ALASKA NATIVE <input type="checkbox"/> ASIAN <input type="checkbox"/> BLACK/AFRICAN AMERICAN <input type="checkbox"/> NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER <input type="checkbox"/> WHITE <input type="checkbox"/> OTHER <input type="checkbox"/> UNKNOWN <input type="checkbox"/> DECLINE			

EMERGENCY CONTACT			
NAME		OTHER NAMES/ALIASES, PREFERRED PRONOUNS	RELATIONSHIP
STREET ADDRESS		CITY, STATE	ZIP CODE
			CELL PHONE, INCLUDING AREA CODE

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		
<p>I hereby authorize the healthcare providers of the University of Florida (UF) Student Health Care Center (SHCC) at Santa Fe College (SFC), their agents or consultants, to perform diagnostic and treatment procedures that, in their judgment, may become necessary while at SFC. 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.</p> <p>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.</p>		
PATIENT NAME - PRINTED	PATIENT SIGNATURE	DATE
<i>FOR OFFICE USE ONLY: PROVIDER NAME - PRINTED</i>	<i>PROVIDER SIGNATURE</i>	<i>DATE</i>