DOUGLAS WILLIAMS EXECUTIVE HEALTH PROGRAM

UFHealth
UNIVERSITY OF FLORIDA HEALTH

RETURN
PATIENT
MEDICAL HISTORY
QUESTIONNAIRE

Since this is your medical history and it will be used in evaluating your health, it is extremely important that the questions be answered as accurately and completely as possible. All the information provided is kept confidential.

Patient Name: _____

Email: _____

Please only update items that have changed since your last visit

PRIMARY CARE PHYSICIAN INFORMATION

Do you want a copy of your final report and all other documents relating to this medical examination sent to your personal physician? ☐ Yes ☐ No

Last Name of Primary Care Physician:

First Name:

Mailing Address- Number & Street:

City: State: Zip Code:

Phone Number: - -

Fax Number: - -

GENERAL INFORMATION

PREFERRED PHARMACY

Name:

Mailing Address- Number & Street:

City: State: Zip Code:

Phone Number: Fax Number:

CURRENT MEDICATIONS

Please list all medications that you are currently taking (including insulin, oral contraceptives, over- the-counter medications, vitamins, diet supplements, herbal preparations, etc.)

MEDICATION	TAKEN FOR	DOSAGE	DOSES PER DAY	DATE STARTED

PRESENT MEDICAL PROBLEMS

Please list any known medical problems that you have at present

MEDICAL PROBLEM	DATE OF ONSENT	COMMENTS

PAST MEDICAL HISTORY

SIGNIFICANT PAST ILLNESS

Please list any other illnesses you have had as a child or adult

ILLNESS	YEAR(S)	COMMENTS

PAST MEDICAL HISTORY (CONT.)

PAST SURGERY

Please list in chronological order any surgeries (hospital and out-patient) that you have had.

TYPE OF SURGERY	YEAR(S)	COMMENTS
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

DRUG REACTIONS/ALLERGIES

Please list all known reactions/allergies to any medications.

MEDICATION	YEAR(S)	TYPE OF REACTION/ALLERGY
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

IMMUNIZATIONS

1. When was your last Tetanus shot? _____/_____/_____
2. Did you receive the annual flu vaccine? ○Yes ○No Date of last flu vaccine: ____/____/____
3. Have you had a pneumococcal vaccine? ○Yes ○No Date: ____/____/____
4. Have you had a shingles vaccine? ○Yes ○No Date: ____/____/____

DIAGNOSTIC STUDIES

Please indicate if you have had any of the below diagnostic studies performed and include month and year they were performed.

TEST	MONTH/YEAR	COMMENTS
○ EKG or ECG (Electorcardiogram)	_____	_____
○ Treadmill or Exercise Stress Test	_____	_____
○ Chest X-ray	_____	_____
○ Bone Densitometry	_____	_____
○ Sigmoidoscopy or Colonoscopy	_____	_____
○ Mammogram	_____	_____
○ Pelvic Exam/Pap Smear	_____	_____
○ PSA (Prostate Specific Antigen)	_____	_____
○ Rectal Exam	_____	_____

SOCIAL/LIFESTYLE HISTORY

PERSONAL INFORMATION

1. Has your marital status changed since your last visit? ◯ Yes ◯ No
1. Current marital status: ◯ Single ◯ Married ◯ Separated ◯ Divorced ◯ Widowed
   - If currently married, how many years? _____
2. Number of children? _____

You are not required to answer the following questions: however, the answers may help your physician provide you with better advice and treatment.

3. Do you have a specific religion? ◯ Yes (Specify): _____ ◯ No
4. Do you find your sexual life to be satisfactory? ◯ Yes ◯ No
5. What is your sexual orientation? ◯ Heterosexual ◯ Homosexual ◯ Bisexual
6. Do you have more than one sexual partner per year? ◯ Yes ◯ No

EDUCATIONAL INFORMATION

1. Have you had any more education since your last visit? ◯ Yes ◯ No

   If yes, please explain.

   _____

   _____

OCCUPATIONAL INFORMATION

Employment Status: ◯Full-time ◯ Part-time ◯Unemployed ◯Semi-retired ◯ Retired ◯Homemaker ◯Student

If retired, give retirement date: _____/_____/_____

Name of business or employer, if employed:

Type of business:

Your position, title, or type of work:

Time with current employer:

_____ Years _____ Months

SOCIAL/LIFESTYLE HISTORY (CONT.)

PERSONAL HABITS

TOBACCO:

1. Do you live with people who smoke? ◯ Yes ◯ No
2. Did your parents smoke when you were growing up? ◯ Yes ◯ No
3. Have you ever used tobacco? ◯ Yes ◯ No (if no, skip to Alcohol section)
4. Do you currently use tobacco? ◯ Yes ◯ No (if no, skip to question 5)
   - If you smoke cigarettes, how many per day? _____ Year started? _____
   - If you smoke cigars, how many per day? _____ Year started? _____
   - If you smoke a pipe, how many pipe fills per day? _____ Year started? _____
   - If you use "smokeless" tobacco, how many times per day? _____ Year started? _____
5. Please identify which of the following you have used in the past

	How many per day?	What year did you start?	What year did you stop?
◯ Cigarettes	_____	_____	_____
◯ Cigars	_____	_____	_____
◯ Pipe	_____	_____	_____
◯ "Smokeless" tobacco	_____	_____	_____

ALCOHOL:

1. Do you drink alcoholic beverages?
   - If yes, please identify which of the following you consume:

	How many per week?
◯ Beer (12 oz)	_____
◯ Wine (6 oz)	_____
◯ Liquor (1.5 oz)	_____

2. Have you used alcohol in the past but subsequently quit? ◯ Yes ◯ No
3. Do you now or have you ever had problems with excessive alcohol use? ◯ Yes ◯ No

ILLICIT/REACRATIONAL DRUGS:

1. Do you now or have you ever used illicit/recreational drugs? ◯ Yes ◯ No

Comments:

_____

_____

SOCIAL/LIFESTYLE HISTORY (CONT.)

PHYSICAL EXERCISE

1. How do rate your current level of physical activity compared to others of your same age and sex?
   - ❖ Think about both leisure and work activities

○ Extremely active ○ Active ○ Somewhat Active ○ Average ○ Somewhat Inactive

○ Inactive ○ Extremely Inactive

2. Compared to a year ago, how much regular exercise do you currently get?

○ Much less ○ Somewhat less ○ About the same ○ Somewhat more ○ Much more

3. Are you currently involved in a regular exercise program? ○ Yes ○ No
4. How often do you exercise?

○ Never ○ Rarely ○ Once a week ○ Several times a week ○ Daily

5. What type of exercise?

_____

_____

FAMILY MEDICAL HISTORY

1. Have your parents' medical history changed since your last visit, including death? ○ Yes ○ No
   - ❖ If yes, please answer the following questions
     1. Current age if living _____
     2. Age at death _____
     3. Medical issue(s) _____
2. Have your sibling(s) medical history changed since your last visit, including death? ○ Yes ○ No
   - ❖ If yes, please answer the following questions
     1. Current age if living _____
     2. Age at death _____
     3. Medical issue(s) _____
3. Have you had any children since your last visit or has your children(s) medical history changed, including death? ○ Yes ○ No
   - ❖ If yes, please answer the following questions
     1. Current age if living _____
     2. Age at death _____
     3. Medical issue(s) _____
4. Have any other family members had medical issues? ○ Yes ○ No
   - ❖ If yes, please explain

     _____

     _____

     _____

REVIEW OF SYSTEMS

Please indicate whether you have ever had a significant problem with any of the symptoms or conditions listed below

GENERAL	YES	NO	UNSURE	IF YES, YEAR OF ONSET	IS THIS STILL A PROBLEM?		COMMENTS
1. Unexplained weight loss	○	○	○	_____	Yes	No	_____
• What was the magnitude of this weight loss? **(Circle one)** 0-5lbs 5-15lbs 15-25lbs >25lbs							
2. Unexplained weight gain	○	○	○	_____	Yes	No	_____
• What was the magnitude of this weight gain? **(Circle one)** 0-5lbs 5-15lbs 15-25lbs >25lbs							
3. Chronic fatigue	○	○	○	_____	Yes	No	_____
4. Change in appetite	○	○	○	_____	Yes	No	_____
5. Night sweats	○	○	○	_____	Yes	No	_____
6. Fever or chills	○	○	○	_____	Yes	No	_____
7. Any type of cancer	○	○	○	_____	Yes	No	_____

HEART/VASCULAR	YES	NO	UNSURE	IF YES, YEAR OF ONSET	IS THIS STILL A PROBLEM?		COMMENTS
8. Chest pain or pressure	○	○	○	_____	Yes	No	_____
9. Chest pain with exertion	○	○	○	_____	Yes	No	_____
10. Heart attack	○	○	○	_____	Yes	No	_____
11. Rapid/irregular heartbeats	○	○	○	_____	Yes	No	_____
12. Fainting/Lightheadedness	○	○	○	_____	Yes	No	_____
13. High blood pressure	○	○	○	_____	Yes	No	_____
14. Rheumatic fever	○	○	○	_____	Yes	No	_____
15. Calf pain with exercise	○	○	○	_____	Yes	No	_____
16. Varicose veins	○	○	○	_____	Yes	No	_____
17. Phlebitis	○	○	○	_____	Yes	No	_____
18. Stroke	○	○	○	_____	Yes	No	_____
19. High blood cholesterol	○	○	○	_____	Yes	No	_____
20. High blood triglycerides	○	○	○	_____	Yes	No	_____

REVIEW OF SYSTEMS (CONT.)

Please indicate whether you have ever had a significant problem with any of the symptoms or conditions listed below

EYES	YES	NO	UNSURE	IF YES, YEAR OF ONSET	IS THIS STILL A PROBLEM?		COMMENTS
21. Decrease in vision Date of last eye exam? _____/_____/_____	○	○	○	_____	Yes	No	_____
22. Double vision	○	○	○	_____	Yes	No	_____
23. Glaucoma	○	○	○	_____	Yes	No	_____
24. Color blindness	○	○	○	_____	Yes	No	_____
25. Cataracts	○	○	○	_____	Yes	No	_____
26. Serious injury to eye	○	○	○	_____	Yes	No	_____

EAR/NOSE/THROAT	YES	NO	UNSURE	IF YES, YEAR OF ONSET	IS THIS STILL A PROBLEM?		COMMENTS
27. Hearing loss	○	○	○	_____	Yes	No	_____
28. Prolonged exposure to loud noise	○	○	○	_____	Yes	No	_____
29. Ringing in ears	○	○	○	_____	Yes	No	_____
30. Chronic ear infections	○	○	○	_____	Yes	No	_____
31. Ruptured eardrum	○	○	○	_____	Yes	No	_____
32. Snoring	○	○	○	_____	Yes	No	_____
33. Sinus infection	○	○	○	_____	Yes	No	_____
34. Allergy related nasal congestion	○	○	○	_____	Yes	No	_____

BONE AND JOINT	YES	NO	UNSURE	IF YES, YEAR OF ONSET	IS THIS STILL A PROBLEM?		COMMENTS
35. Chronic joint and muscle pain	○	○	○	_____	Yes	No	_____
36. Low back pain	○	○	○	_____	Yes	No	_____
37. Swollen/stiff joints	○	○	○	_____	Yes	No	_____
38. Arthritis	○	○	○	_____	Yes	No	_____
39. Gout	○	○	○	_____	Yes	No	_____

REVIEW OF SYSTEMS (CONT.)

Please indicate whether you have ever had a significant problem with any of the symptoms or conditions listed below

ENDOCRINE	YES	NO	UNSURE	IF YES, YEAR OF ONSET	IS THIS STILL A PROBLEM?		COMMENTS
40. Thyroid disease	○	○	○	_____	Yes	No	_____
41. High blood sugar	○	○	○	_____	Yes	No	_____
42. Low blood sugar	○	○	○	_____	Yes	No	_____
43. Diabetes	○	○	○	_____	Yes	No	_____

PULMONARY	YES	NO	UNSURE	IF YES, YEAR OF ONSET	IS THIS STILL A PROBLEM?		COMMENTS
44. Chronic cough or phlegm	○	○	○	_____	Yes	No	_____
45. Wheezing	○	○	○	_____	Yes	No	_____
46. Asthma	○	○	○	_____	Yes	No	_____
47. Tuberculosis	○	○	○	_____	Yes	No	_____
48. Bronchitis	○	○	○	_____	Yes	No	_____
49. Pneumonia	○	○	○	_____	Yes	No	_____
50. Emphysema	○	○	○	_____	Yes	No	_____
51. Coughing up blood	○	○	○	_____	Yes	No	_____
52. Shortness of breath	○	○	○	_____	Yes	No	_____

GASTROINTESTINAL	YES	NO	UNSURE	IF YES, YEAR OF ONSET	IS THIS STILL A PROBLEM?		COMMENTS
53. Fatty food intolerance	○	○	○	_____	Yes	No	_____
54. Ulcer disease	○	○	○	_____	Yes	No	_____
55. Frequent heartburn	○	○	○	_____	Yes	No	_____
56. Vomiting blood	○	○	○	_____	Yes	No	_____
57. Gallbladder trouble	○	○	○	_____	Yes	No	_____
58. Abdominal pain	○	○	○	_____	Yes	No	_____
59. Jaundice, hepatitis, or cirrhosis	○	○	○	_____	Yes	No	_____
60. Frequent diarrhea	○	○	○	_____	Yes	No	_____
61. Diarrhea caused by milk/ Lactose intolerance	○	○	○	_____	Yes	No	_____
62. Blood in stools	○	○	○	_____	Yes	No	_____

REVIEW OF SYSTEMS (CONT.)

Please indicate whether you have ever had a significant problem with any of the symptoms or conditions listed below

GASTROINTESTINAL	YES	NO	UNSURE	IF YES, YEAR OF ONSET	IS THIS STILL A PROBLEM?		COMMENTS
63. Black stools	○	○	○	_____	Yes	No	_____
64. Hemorrhoids	○	○	○	_____	Yes	No	_____
65. Colon polyps	○	○	○	_____	Yes	No	_____
66. Chronic constipation	○	○	○	_____	Yes	No	_____

NEUROPSYCHIATRY	YES	NO	UNSURE	IF YES, YEAR OF ONSET	IS THIS STILL A PROBLEM?		COMMENTS
67. Loss of consciousness	○	○	○	_____	Yes	No	_____
68. Vertigo	○	○	○	_____	Yes	No	_____
69. Memory problems	○	○	○	_____	Yes	No	_____
70. Seizures of epilepsy	○	○	○	_____	Yes	No	_____
71. Frequent headaches	○	○	○	_____	Yes	No	_____
72. Difficulty sleeping	○	○	○	_____	Yes	No	_____
73. Depression	○	○	○	_____	Yes	No	_____
74. Anxiety	○	○	○	_____	Yes	No	_____
75. Thoughts of suicide	○	○	○	_____	Yes	No	_____
76. Nervous breakdown	○	○	○	_____	Yes	No	_____
77. Numbness or tingling of arms, legs, or face	○	○	○	_____	Yes	No	_____
78. Psychiatric or psychological counseling	○	○	○	_____	Yes	No	_____

HEMATOLOGY	YES	NO	UNSURE	IF YES, YEAR OF ONSET	IS THIS STILL A PROBLEM?		COMMENTS
79. Anemia	○	○	○	_____	Yes	No	_____
80. Bleeding disorder	○	○	○	_____	Yes	No	_____
81. Previous blood transfusion	○	○	○	_____	Yes	No	_____
82. Enlarged or swollen lymph nodes	○	○	○	_____	Yes	No	_____

REVIEW OF SYSTEMS (CONT.)

Please indicate whether you have ever had a significant problem with any of the symptoms or conditions listed below

DERMATOLOGY	YES	NO	UNSURE	IF YES, YEAR OF ONSET	IS THIS STILL A PROBLEM?		COMMENTS
83. Skin rash	○	○	○	_____	Yes	No	_____
84. Skin cancer	○	○	○	_____	Yes	No	_____
85. Shingles/herpes zoster	○	○	○	_____	Yes	No	_____
86. Skin sores that won't heal	○	○	○	_____	Yes	No	_____
87. Unusual moles	○	○	○	_____	Yes	No	_____
88. Skin or toenail fungus	○	○	○	_____	Yes	No	_____
89. Psoriasis	○	○	○	_____	Yes	No	_____
90. Mouth sores that won't heal	○	○	○	_____	Yes	No	_____
91. Other (Specify)_____	○	○	○	_____	Yes	No	_____

GENITOURINARY	YES	NO	UNSURE	IF YES, YEAR OF ONSET	IS THIS STILL A PROBLEM?		COMMENTS
92. Blood in urine	○	○	○	_____	Yes	No	_____
93. Kidney stones	○	○	○	_____	Yes	No	_____
94. Kidney/bladder infection	○	○	○	_____	Yes	No	_____
95. Burning or pain during urination	○	○	○	_____	Yes	No	_____
96. HIV positive/AIDS	○	○	○	_____	Yes	No	_____
97. Sexually transmitted disease							
• Syphilis	○	○	○	_____	Yes	No	_____
• Gonorrhea	○	○	○	_____	Yes	No	_____
• Herpes	○	○	○	_____	Yes	No	_____

REVIEW OF SYSTEMS (CONT.)

Please indicate whether you have ever had a significant problem with any of the symptoms or conditions listed below

GENITOURINARY (MALES ONLY)	YES	NO	UNSURE	IF YES, YEAR OF ONSET	IS THIS STILL A PROBLEM?		COMMENTS
98. Impotence/erectile Dysfunction	○	○	○	_____	YES	NO	_____
99. Difficulty urinating (starting or stopping)	○	○	○	_____	YES	NO	_____
100. Awaking to urinate	○	○	○	_____	YES	NO	_____
101. Prostate trouble	○	○	○	_____	YES	NO	_____

GENITOURINARY
(FEMALES ONLY)

102. Sexual problems (ex. Pain with intercourse) ○ YES ○ NO

If yes, please comment:

_____

_____

103. How many times have you been pregnant? _____

104. Number of miscarriages or abortions: _____

105. Are you still having menstrual cycles? ○ YES ○ NO

106. Date of last menstrual cycle: _____/_____/_____

107. How many days does your menstrual cycle typically last? _____

108. How often do you get your menstrual cycle? _____

109. Do you have any problems with your menstrual cycle? ○ YES ○ NO

If yes, please comment:

_____

_____

Thank you for your time and patience in completing this questionnaire. If you have any questions or concerns, please call us at 352-265-8262 or 800-556- EXEC (3932)