THE UNIVERSITY OF TEXAS
STUDENT HEALTH CLINIC
3410 Patriot Drive Tyler, Texas 75701

Patient Name: _____
Patient MRN: _____

HEALTH SURVEY

INTRODUCTION

Please complete this survey prior to your appointment. It is intended to establish a number of basic health facts which are important to the analysis of your problem(s) and to gain a comprehensive picture of your health. It is not intended to substitute for a personal interview – it is intended to insure that as much time as possible will be spent discussing health problems that concern you.

Name: _____ **Date:** _____

Address: _____ **Telephone Number:** _____

CHIEF COMPLAINT

Briefly describe your main reason(s) for coming to the doctor today. _____

_____

_____

_____

SOCIAL HISTORY

A. HABITS

1. Do you smoke? _____If so, how much?_____How many years?_____

2. Do you drink alcoholic beverages? _____If so, how many beers or drinks in an average week?

_____

3. Do you take a regular form of exercise? _____If so, how often?_____

What kind?_____ For how long? _____

4. Do you drink coffee or tea? _____If so, how many cups/day? _____

5. Do you follow any particular diet? _____If so, what kind and for what reason?_____

_____

6. Do you take any prescriptions or medications that were not prescribed for you?_____

_____

7. Do you have a history of drug abuse? _____If so, please elaborate _____

_____

Patient Name _____
MRN _____

B. OCCUPATION

1. What kind of work do you do? _____

2. How long have you done this kind of work? _____

Hours / week _____

3. Are you satisfied with your work? _____

4. What kinds of jobs have you held in the past? _____

_____

5. Are you aware of any hazardous exposures or other health problems associated with your present or past jobs? _____

6. Have you ever changed jobs for health reasons? _____

7. Were you in the military? _____If so, for how long?_____

Were you medically retired or refused entry into active duty for health reasons? _____

_____

8. Have you received Workman's Compensation or other disability? _____If so, please elaborate.

_____

B. PERSONAL

1. Are you: Married _____ Single _____Separated _____Divorced _____ Widowed _____

2. How many years' education did you complete? grade school _____ High school _____college _____ professional _____ technical, business _____

3. What kind of hobbies do you enjoy? _____

4. Where were you born? _____

5. Where else have you lived? _____

_____

Patient name: _____MRN#_____

FAMILY HISTORY **FAMILY** Print the names of your relatives living or dead in the list below. If there is not enough spaces, place an (X) here. ❑	Please follow the instructions given for each heading outlined below:																						
	YEAR OF BIRTH HEALTH STATUS Give the year of birth for all your relatives at the left and mark an (X) to indicate whether their health is good or poor.	ILLNESSES Place an (X) in the appropriate column for any illnesses that you or the relatives listed at the left have now or have had																			DEATHS If a relative you have listed has died write the cause of death and the age at death in the columns below	
	Year of Birth	Good	Poor	Allergies or Asthma	Anemia	Bleeding Tendencies	Cancer or Tumor	Diabetes	Epilepsy	Glaucoma	Gout	Heart Trouble	High Blood Pressure	Kidney or Bladder Trouble	Nervous Breakdown	Rheumatism or Arthritis	Stomach or Duodenal Ulcer	Stroke	Tuberculosis	**Cause of Death**	**Age**
Father:																					
Mother:																					
Brothers or Sisters:																					
Spouse:																					
Children:																					
Grandparents (Mark an (X) for illnesses only)																					
YOUR ILLNESSES: Start here ⟶																					

PAST HISTORY

1. INFECTIONS – Check the illnesses which you have had.

____measles ____mumps ____whooping cough ____mononucleosis

____scarlet fever ____typhoid fever ____chickenpox ____hepatitis

____rheumatic fever ____nephritis ____venereal disease (gonorrhea, syphilis, NSU)

2. SURGERY – Fill in as much information as you can

Date **Operation** **Surgeon** **Hospital** **Reason Done**

a. _____

b. _____

c. _____

3. HOSPITALIZATIONS (OTHER THAN SURGERY)

Date **Reason** **Doctor** **Hospital**

a. _____

b. _____

Patient name: _____MRN#_____

4. MEDICAL ILLNESSES – Please indicate if you have any of the following with approximate age at onset:

_____ hay fever
_____ cataracts
_____ pneumonia
_____ high blood pressure
_____ circulatory problem
_____ ulcers
_____ hemorrhoids
_____ pancreatitis
_____ prostate trouble
_____ anemia
_____ diabetes
_____ arthritis
_____ epilepsy
_____ meningitis
_____ other

_____ asthma
_____ glaucoma
_____ chronic bronchitis
_____ heart disease
_____ varicose veins
_____ GI bleeding
_____ cirrhosis
_____ kidney infections
_____ hernia
_____ bleeding disorder
_____ thyroid disease
_____ cancer
_____ stroke
_____ severe depression

_____ chronic hives
_____ other eye disease
_____ emphysema
_____ tuberculosis
_____ phlebitis
_____ colitis
_____ gallstones
_____ kidney stones
_____ pregnancies
_____ blood transfusion
_____ high lipids (fats)
_____ gout
_____ concussion
_____ drug abuse

5. **INJURIES**

Date	Type injury	Doctor	Hospital
a.			
b.			

6. MEDICATIONS – List the medications that you are on; please include over the counter meds, vitamins and herbal preparations.

Medication	Reason	Medication	Reason

7. ALLERGIES – List medications which you cannot take and the problem it causes

Medication	Reaction	Medication	Reaction

8. IMMUNIZATIONS – indicate the date of your last booster

_____ diphtheria, tetanus
_____ smallpox
_____ oral polio
_____ flu shot
_____ measles, mumps, rubella
_____ TB skin test

9. DIAGNOSTIC PROCEDURES – Indicate if and when you have had any of the following:

_____ chest x-ray
_____ colon x-ray
_____ ECG
_____ pap smear
_____ kidney x-ray (IVP)
_____ gallbladder x-ray
_____ pulmonary function
_____ mammogram
_____ GI series
_____ proctoscopy
_____ dental work