



New Patient Questionnaire

Student ID # _____
SSN: _____

Legal Name: _____ Preferred Name: _____
Last First MI

Date of Birth: _____
 Local Phone # _____

Local Address: _____

Permanent Address: _____

Emergency Contact: _____
Name

Relationship Phone #

Military Service: Yes No
Current military status: Active Duty
 National Guard Reserve Veteran
Branch of Service: Air Force Army Navy
 Marine Corps Coast Guard
Birth gender: M F Intersex
What is your sexual orientation?
 Bisexual Gay Lesbian Queer
 Straight-heterosexual prefer not to answer
What is your gender identity?
 feminine masculine androgynous
 gender neutral transgender
 prefer not to answer

Medical Insurance: _____
Insurer Policy # Phone #

MEDICAL HISTORY

Please list all surgeries and medical problems you have or had: _____

Do you use tobacco? Yes No Do you use alcohol or other drugs? Yes No

Do you have allergies? ____ Yes ____ No **Are you receiving allergy injections?** ____ Yes ____ No

Please specify allergy:
 Aspirin Sulfa drugs Penicillin Other drugs (which?) _____
 Insect sting Food allergy (which?) _____ Other allergies? _____

FAMILY HISTORY: Has any person, related to you by blood, had any of the following:

	Yes	No	Relationship		Yes	No	Relationship		Yes	No	Relationship
High Blood Pressure				Cancer (type)				Cholesterol or blood fat disorder			
Stroke				Alcohol/drug problem				Diabetes			
Heart attack before age 55				Psychiatric illness				Glaucoma			
Blood/clotting disorder				Suicide				Asthma			
Other _____				Tuberculosis				Obesity			

- I understand that **I am financially responsible for all charges incurred at Student Health Services and that my student health fee does not cover charges for services delivered by community providers that I may be referred to or utilize.**
- I am aware of the confidentiality and privacy practices of Student Health Services, of my right to review my medical record and to obtain copies of these records. Fees may apply after receiving a courtesy copy of records.
- My signature below authorizes Student Health Services to share my medical information as necessary to medical/social service providers, facilities, pharmacies and insurers to coordinate my care and to facilitate payment.

Signature: _____ Date: _____

Confidentiality and Collection of Social Security Numbers

Student Health Services follows all applicable state and federal regulations and university policies regarding the privacy and confidentiality of medical records. Information will not be divulged without appropriate written consent from the patient except in case of emergency or as required by law. In compliance with the provisions of Section 119.071(5), Florida Statutes, Student Health Services collects social security numbers for legitimate business purposes, as specifically authorized by law and in the performance of the duties and responsibilities for the following reasons: 1) completion of the Florida Department of Health Practitioner Disease Report Form and 2) to secure healthcare services and/or insurance benefits for the individual.