UCONN HEALTH

Occupational/Environmental Medicine
Student Health Services

(Patient Identification)

Health Questionnaire for Incoming Students

Name _____Date of Birth_____

Home Address: _____

Cell Phone #: _____ Other phone #: _____ UCHC email: _____

Year enrolled _____ Level enrolled ☐Year One OR _____ Expected graduation date _____

TRAVEL AND LIVING HISTORY: Have you lived or travelled more than 3 months outside North America and Western Europe? ☐NO ☐YES If yes, please explain

_____

_____

WORK AND EXPOSURE HISTORY: Have you ever worked in an environment that was noisy enough that hearing testing or hearing protection was recommended? OR spent time in an environment that exposed you to potentially toxic environmental substances such as organic solvents, mold, formaldehyde, or infectious conditions such as TB, OR had to lose more than a week of work or had to change jobs due to illness or injury, whether or not job-related? (Include both paid positions and volunteer / educational positions including research labs.) ☐ NO ☐ YES. If yes, please explain

_____

_____

_____

LIVING AND LEISURE TIME ACTIVITIES HISTORY: Have you been exposed to any other hazards at home or doing hobbies OR have you ever changed your residence because of a health problem OR do you live near an industrial plant or hazardous waste site? ☐NO ☐ YES If yes, please explain

_____

_____

ACADEMIC HISTORY: In your prior study, have you experienced a time when the demands were so overwhelming that you needed special help or your performance plummeted due to stress? ☐ NO ☐ YES If yes, please explain

_____

_____

SPECIAL CONCERNS: Do you have any personal health problems that might be affected by work or workplace exposures, OR do you think you will need any special accommodations to help you succeed in your studies?
☐ No ☐ Yes If yes, please explain

_____

MEDICAL HISTORY – Check if you have or have had any of the following and give the year. (Please see next page).

HCH2572

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Illness	Yes		Illness	Yes		Illness	Yes
Dizziness, loss of consciousness, or fainting			Sinus problems, nasal congestion, persistent or recurrent cough			Ear Infection, ruptured ear drum, hearing loss or hearing deficit	
Heart problems, irregular heartbeats, skipped beats, palpitations			Throat or voice problems, difficulties swallowing, thyroid disease			Epilepsy or seizures	
Angina, heart attack, congestive heart failure, enlarged heart, or heart murmur			Varicose veins, leg swelling, or leg sores			Neurological disorder, difficulties with balance, coordination, speech, memory or use of limbs	
High blood pressure or elevated cholesterol levels			Hernia			Head Injuries, migraines, frequent headaches	
Chest tightness, chest pain, shortness of breath			Weight change (increase or loss without trying)			Elbow, wrist or hand problems	
Diabetes, high blood sugar, or low blood sugar			Anemia, blood clots ,or other blood disorder			Carpal tunnel syndrome, tingling or numbness in hands	
Cancer or immunodeficiency			Pinched nerve or disc problem			Bursitis/ tendonitis	
Recurrent bronchitis, emphysema, pneumonia, or other lung disease			Sleep apnea , difficulties sleeping, or other sleep disorder			Recurrent neck problems – strain, sprain, whiplash, stiffness	
Asthma, breathing problems, or wheezing			Vision problems			Shoulder problems/injury such as rotator cuff injury	
Tuberculosis			Absent spleen			Tendonitis/repetitive strain Injury	
Skin rashes; psoriasis, eczema, other skin sensitivity			Urinary or kidney problems			Hip, knee, ankle or foot problems	
Anxiety, depression that interferes with function, overwhelming stress, mood disorder, phobias or fears			Mental health condition that may interfere with concentration or interpersonal relationships			Recurrent back problems – sprain, strain, injury, stiffness	
Liver problems, hepatitis, cirrhosis, or pancreas problems			Gastrointestinal Disease – GERD, ulcers, bowel disease, irritable bowel syndrome, blood in stools			Chronic pain, fibromyalgia, myofascial pain disorder, or muscle problems	
Weakness or chronic fatigue			Multiple chemical sensitivities, or sensitivities to odors or fragrances			Arthritis, Lyme Disease, or other joint problem	
Connective tissue disorder such as Lupus, Sarcoidosis, Sjogren's Syndrome			Alcoholism or drug addiction			Difficulties standing, walking, climbing, using stairs	

Please comment on the above conditions:

_____

_____

Have you ever been hospitalized? ☐ Yes ☐ No

(Patient Identification)

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Please list any hospitalizations and/or surgeries for major medical illnesses, injury, or procedures: _____

_____

_____

Do you have any other medical condition not identified on the previous page? Please describe and give dates:

_____

_____

Please list current medications, including prescription medicines, over the counter medicines, vitamins and supplements, and complementary / alternative treatments:

_____

_____

ALLERGY HISTORY. Please list any allergies to:

Medications _____

Animals _____

Foods _____

Stinging insects _____

Chemicals, odors, fragrances, or environmental and/or indoor air allergens (include sensitivities of any sort) _____

_____

_____

Are you allergic to protective gloves or Latex (glove dermatitis) ☐ No ☐ Yes

FAMILY HISTORY

Is there illness among your blood relatives that you are concerned might affect your own risk of disease? (Examples are diabetes, premature coronary disease, sickle cell anemia, schizophrenia, unusual cancers, or multiple people with cancer ☐ No ☐ Yes If Yes, please explain:

_____

_____

_____

HEALTH MAINTENANCE & SCREENING

Do you currently have a primary care physician? ☐ No ☐ Yes

If yes, name & city/state_____

Will you continue accessing this provider for routine exams and screenings? ☐ No ☐ Yes
Will you continue accessing this provider for episodic (illness-related) care? ☐ No ☐ Yes

Do you wear a seatbelt in a car? ☐ Yes ☐ No

What year was your last complete physical exam? _____

What year was your last vision (eye) exam? _____

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What year was your last dental cleaning? _____ Do you floss your teeth regularly? ☐ No ☐ Yes

For women only, what year was your last cervical cancer screening (Pap smear)? _____

What year was your last cholesterol screening test? _____

PERSONAL ATTRIBUTES AND ACTIVITIES

Do you frequently have trouble initiating or maintaining sleep? ☐ No ☐ Yes

Do you feel excessively tired during the day because work/study demands keep you out of bed? ☐ No ☐ Yes

Do you feel more stress than your peers from family responsibilities or problems with those close to you? ☐ No ☐ Yes

Do you feel like you have limited social and emotional support from friends and family members? ☐ No ☐ Yes

Please explain any 'Yes' answers: _____

Do you use tobacco? ☐ No, never ☐ No, but I did in the past ☐ Yes, currently

If you ever used tobacco, what did you use? ☐ Cigarettes ☐ Pipe or Cigars ☐ Chewing

How old were you when you started to use tobacco? _____ How old were you when you stopped? _____

How much, on average, do you smoke now or did you smoke when you were smoking?

____ packs cigarettes/day or ____ cigars/pipes per week

Do you drink alcohol? ☐ No ☐ Yes If yes, how many drinks do you average per week? _____

What is the most drinks you are likely to have on a single occasion? _____

(A drink is defined as 12 ounces of beer, 5.5 ounces of wine, of 1.5 ounces of hard liquor)

How many minutes of deliberate exercise (includes brisk walking) do you get per week? _____

What sort of exercise do you prefer / engage in frequently? _____

As you enter a new phase in your education, do you anticipate problems maintaining exercise patterns? ☐ No ☐ Yes

Do you observe any dietary restrictions, or follow any sort of diet for purposes of maintaining your health? ☐ No ☐ Yes

Have you gained or lost more than 15 pounds in the last 4 years? ☐ No ☐ Yes

If Yes, what was your response to this? _____

Currently, do you consider your body habitus / weight about 'right' for you? ☐ No ☐ Yes

Comments on any of the above: _____

I understand that the purpose of this exam is to screen for medical and physical conditions, assess whether any testing or treatment is necessary, assure that I have had all necessary immunizations and screening to reduce the likelihood that I will either contract a communicable illness or pass it on to my patients or other staff, assure that any necessary accommodations are available to that I can safely proceed with medical education, and advise me on lifestyle and medical interventions needed to maintain my health and wellness.

I understand that the details of the exam remain confidential within the medical record, but the Medical School may be advised regarding the need for accommodation if I believe I need such accommodation.

I certify to the best of my knowledge that the above information is complete and true.

I understand that this evaluation (history review and physical exam) is related to my role as a student and does not replace routine health care and physical examinations by my own doctor.

Patient Signature: _____ Date _____Time_____

Reviewed By: _____ Date _____Time_____