UNIVERSITY OF FLORIDA POST-OFFER PHYSICAL EXAM

MEDICAL HISTORY

NAME: _____ UF ID: _____ Gender at Birth: _____
Last First MI

ADDRESS: _____
Street City State Zip

CELL PHONE: _____ DATE OF BIRTH (MM/DD/YYYY): _____

As part of our effort to insure that your employment with the University does not worsen any pre-existing medical problem, we ask that you answer the following questions. This history and physical is not a substitute for a comprehensive examination by your personal physician and does not include cancer screening, cholesterol testing, etc. Any of our findings will be shared with you and your physician upon request. We are not authorized to treat conditions detected during this exam.

GINA Disclosure: "The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services."

Indicate below if you currently have or ever been treated for any of the following conditions, if you answer yes to any questions please explain in space below: _____

YES	NO		YES	NO	
☐	☐	Anemia	☐	☐	Immune System Disorder
☐	☐	Ankle /Foot Injury/Problem	☐	☐	Indoor Air Problem
☐	☐	Arthritis (state type)	☐	☐	Kidney Disease/Disorder
☐	☐	Asthma	☐	☐	Knee Injury/Problem
☐	☐	Back Injury	☐	☐	Liver Disease
☐	☐	Cancer History	☐	☐	Neck Injury/Problem
☐	☐	Claustrophobia	☐	☐	Psychiatric concern (i.e. anxiety/depression)
☐	☐	Diabetes (indicate Type 1 or Type 2)	☐	☐	Seizures
☐	☐	Finger/Hand Injury/Problem	☐	☐	Severe Headaches (Migraines)
☐	☐	Hay Fever/allergies	☐	☐	Shoulder Injury
☐	☐	Head Injury/Loss of Consciousness	☐	☐	Surgery (including minor surgeries)
☐	☐	Heart Disease	☐	☐	Thyroid Disease
☐	☐	Heat Disorders	☐	☐	Tuberculosis
☐	☐	Herniated Disc	☐	☐	Ulcers
☐	☐	High Blood Pressure	☐	☐	Wrist Injury/Problem
☐	☐	Hip Injury/Problem	☐	☐	Work-Related Injury/Illness
			☐	☐	Other disorder: _____

Explanation for "Yes" responses (include dates, treatments and if issue is resolved):

_____

_____

_____

Provider Comments: _____

_____

_____

Medication Allergies: No____ Yes (list): _____

Current Medications AND dosages (include prescribed, supplements, over-the-counter medications, etc.): _____

_____

Do you have any health conditions you think may hinder your performance on the job or may require your work to be modified?

☐ **NO** ☐ **YES** (**Describe)** _____

_____ _____ _____ _____ _____
Employee Signature **Date** **Medical Provider (Print)** **Medical Provider Signature** **Date**

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Review of Systems

NAME: _____ **UF ID:** _____
Last **First** **MI**

Which of the following have been a problem for you **in the last year**?

General/Constitutional	**Heart/Lung**	**Neurologic/Psychiatric**
{ } Fever, >100 degree	{ } Chest pain or pressure	{ } Headaches
{ } Shivering/Chills	{ } Irregular heart beat	{ } Dizziness/passing out (circle one or both)
{ } Generalized weakness	{ } Palpitations/skipped beats	{ } Depression
{ } Unexplained weight loss/gain	{ } New or changed cough	{ } Numbness or tingling
{ } Excessive fatigue	{ } Coughing up blood	{ } Excessive anxiety
{ } Swollen glands	{ } Wheezing	{ } Insomnia/difficulty sleeping
{ } Loss of appetite	{ } Shortness of breath	{ } Loss of memory
{ } None Applicable	{ } None Applicable	{ } None Applicable
Skin/musculoskeletal	**Digestive System**	**Ears, Nose, Throat**
{ } Rashes	{ } Nausea/vomiting	{ } Difficulty hearing
{ } Moles that changed in size or color	{ } Diarrhea/constipation (circle one or both)	{ } Ringing, buzzing
{ } Muscle pain	{ } Yellow jaundice	{ } Sinus trouble
{ } Back pain	{ } Rectal bleeding or black tarry stools	{ } Sneezing/runny nose
{ } Neck pain		{ } Nosebleeds
{ } Weakness in arms/legs	**Genitourinary & Reproductive**	{ } Difficulty swallowing
{ } Joint pain	{ } Difficult or painful urination	{ } None Applicable
{ } None Applicable	{ } Blood in urine	
		(Men only)
	{ } None Applicable	{ } History of hernia
Eyes	**(Women only)**	**Additional Comments:**
{ } Change in vision	{ } Irregular periods/spotting	
{ } Itching	{ } History of hernia	
{ } Tearing	{ } Date of last menstrual period _____	
{ } None Applicable		

Social History:_____

Have you ever used tobacco or vaping products? { } Yes { } No

If "yes", When: { } Current { } Past – year quit? _____

Type: { } Cigarettes { } Pipe/Cigar { } Snuff/Chewing { } Vaping/E-cigarettes

Amount per day? _____ For how many years? _____

What is your average alcohol consumption in a week? _____drinks of { } Beer { } Wine { } Hard liquor

(1 drink = 12 oz. beer, 1 glass wine or 1.5 oz. liquor)

If you drink alcohol, what is your usual pattern?

{ } Weekdays { } Weekends { } Both

_____	_____	_____	_____	_____
Employee Signature	**Date**	**Medical Provider (Print)**	**Medical Provider Signature**	**Date**