



Jacksonville Transplant Center
580 West 8th Street, Suite 8000, T36
Jacksonville, FL 32209
P: (904) 244-9800 F: (904) 244-9842

Health History Questionnaire

Name: _____

Date of Birth: _____ Social Security Number: _____

Employer: _____ Occupation: _____

Name of Significant Other/Spouse: _____

Children: Yes No If yes, ages: _____

Do you have any allergies? Yes No If yes, what are you allergic to:

Have you had any recent hospitalizations? Yes No If yes, when and where:

Have you had any operations? Yes No If yes, what type of operations:

Have you had any complications from the surgeries? Yes No

If yes, what type of complications: _____

Have you had general anesthesia? Yes No

Have you had any complications from the anesthesia? Yes No

If yes, what type of complications: _____

Have you had any blood transfusions? Yes No If yes, when and why:

Current Medications:

Are you on any blood thinners? Yes No If yes, what type:

Dental Status: Good Fair Poor Date of last dental visit: _____

How often do you? Brush your teeth: _____ Floss: _____

Do your gums bleed when you brush your teeth? Yes No

Review of Medical Systems:

1. Do you have chronic headaches? Yes No Comment: _____

2. Do you have any loss of feeling in your arms or legs? Yes No
If yes, where: _____

3. Have you ever had problems with bleeding? Yes No

4. Have you ever had a blood clot? Yes No
If yes, where was it and how was it treated: _____

5. Do you have anemia? Yes No

6. Do you have high blood pressure? Yes No

7. Do you have thyroid disease? Yes No

8. Do you have a chronic cough? Yes No

Any wheezing? Yes No

Bronchitis? Yes No

Asthma? Yes No

Tuberculosis? Yes No

If yes, when and what treatment? _____

Pneumonia? Yes No

9. Do you smoke or have you ever smoked? Yes No If yes, how much do you smoke: _____
When did you quit smoking? _____

10. Do you drink beer, wine, or alcohol or have you in the past? Yes No If yes, how often: _____
When did you stop drinking? _____

11. Have you ever had heart disease or a heart attack? Yes No

12. Have you ever had heart surgery? Yes No If yes, when: _____

13. Have you ever had chest pain? Yes No

14. Do you have high cholesterol? Yes No

15. Do you have shortness of breath? Yes No

16. Do you use oxygen? Yes No

17. Do your feet, ankles, or legs swell? Yes No If yes, when: _____

18. Have you ever had gallbladder trouble? Yes No

19. Do you have diabetes? Yes No If yes, do you use insulin, oral medication, or diet control? _____

20. Have you ever been jaundiced? Yes No

21. Have you ever been told you have hepatitis? Yes No If yes, when and what type: _____

22. Have you ever been told you have liver disease? Yes No If yes, what type of liver disease: _____

23. Have you ever had problems with painful urination? Yes No
24. Have you ever had kidney stones? Yes No If yes, when and did you have treatment: _____
25. Have you ever had a urinary tract infection? Yes No If yes, when and did you have treatment and what type of treatment: _____
26. Have you ever had seizures? Yes No If yes, when and are you still being treated: _____
27. Have you ever been diagnosed with cancer? Yes No
 If yes, when, what type, and did you have treatment: _____
28. Have you ever consulted with a psychiatrist? Yes No
29. Have you ever felt the need to see a psychiatrist? Yes No
30. Do you have problems with anxiety? Yes No
31. Do you have any problems with depression? Yes No

Questions only for Males:

1. Do you have regular prostate exams? Yes No
2. Do you have any testicular swelling? Yes No
3. Do you have prostate problems? Yes No

Questions only for Females:

1. Do you have regular Pap Smears and Pelvic Exams? Yes No
 If yes, when was your last one? _____
 If yes, what were the results? _____
2. Do you have regular Mammograms? Yes No
 If yes, when was your last one? _____
 If yes, what were the results? _____
3. How many pregnancies have you had? _____
 If you had pregnancies, how many live births: _____ miscarriages: _____ abortions: _____
4. Did you have vaginal births or C-Sections? _____

Have you had any other medical problems that were not mentioned? Yes No If yes, please list and what treatments are you getting: _____

How do you rank your health status at this present time?

- Excellent Good Fair Poor

Have you ever had: Measles: Yes No
 Mumps: Yes No
 Chickenpox: Yes No
 Rheumatic Fever: Yes No

Have you ever been immunized for the following?

Hepatitis A Yes No If yes, when and where: _____
Hepatitis B Yes No If yes, when and where: _____

Have you received a Tetanus shot? Yes No

Please list:

Primary Care Physician: _____ Phone: _____

Nephrologist: _____ Phone: _____

Cardiologist: _____ Phone: _____

Urologist: _____ Phone: _____

Endocrinologist: _____ Phone: _____

Other Physician(s) and Phone:

HAVE YOU HAD ANY OF THE FOLLOWING TESTS/PROCEDURES

1. CT-SCAN? Yes No If yes, when, where and what part of the body? _____

2. MRI? Yes No If yes, when, where, and what part of the body? _____

3. Ultrasound? Yes No If yes, when where and what part of the body? _____

4. Chest X-Ray? Yes No If yes, when and where? _____

5. Echocardiogram? Yes No If yes, when and where? _____

6. Cardiac Stress Test? Yes No If yes, when and where? _____

7. Cardiac Catheterization? Yes No If yes, when and where? _____

8. Pulmonary Function Testing? Yes No If yes, when and where? _____

9. Upper Endoscopy? Yes No If yes, when and where? _____

10. Colonoscopy? Yes No If yes, when and where? _____

11. Other Tests? Yes No If yes, what kind, when, and where? _____
