

University of Florida Student Health Care Center

Health Risk Profile

Today's Date: _____

Name: _____ Age: _____ Sex: _____ UF Class/Year: _____

UF ID: _____ Social Security Number: _____

The Student Health Care Center is dedicated to promoting good health and wellness just as it is committed to helping you when you are ill. Please complete this Health Risk Profile so we can help you develop a healthier lifestyle. This will become part of your confidential medical record.

Please complete Questions 1-8.

S: 1. In the past 2 weeks, how many times have you had five or more alcoholic drinks?:
0 1 2 3 4 5 6 7 8 9 10 11 12+

How motivated are you to discuss your drinking habits with a health provider?

Not at All Somewhat Moderately Very Not Applicable

2. In the past 6 months, have you ever used tobacco products (any cigarettes, smokeless tobacco, dip, or cigars)?

YES NO If yes, what kind of products? _____

How much do you typically use per week? _____

How motivated are you to quit in the next 30 days? _____

3. Within the past 6 months, have you felt so depressed it was difficult to function?

YES NO If yes, when? _____

4. Within the past 6 months have you experienced prolonged sadness, hopelessness or little interest in doing things?

YES NO If yes, when? _____

5. Have you ever thought about or attempted to hurt yourself?

YES NO If yes, when? _____

6. Have you ever had sexual experiences when you were so intoxicated that you were unable to stop it or say "No"?

YES NO If yes, when? _____

7. Have you ever had sexual experiences against your wishes because someone used force or threatened to harm you?

YES NO If yes, when? _____

8. Please list any other health issues that you'd like to discuss today: _____

O: None/ _____

A: Health Risk Profile Complete

P: No Risks Identified at this time

Risk regarding Question # _____ Comments: _____

Referral to: Mental Health, CARE, Women's Clinic, GatorWell Health Promotion Services, Medical Team

"Important Resources for Students" bookmark given and discussed

Other: _____

Make another appointment to discuss Risk(s): _____

Date Reviewed: _____ Signature: _____,RN