UF Employee Smoking Cessation Program
Employee Health History

Employee Name: _____ UFID#: _____

Employee E-Mail Address: _____ Work Number: _____

Department/College: _____ Date of Birth: _____

Your medical history information is necessary to individualize your smoking cessation program to make sure you have the greatest opportunity for quitting success. Please be honest with your answers. All health information provided will be strictly confidential and filed in your employee health record. This information will not be shared with your employer, supervisor, or any other person with whom you work.

Upon completion of this form, contact Frankie Tai to schedule a brief appointment with one of the SHCC medical providers. At this appointment the medical provider will review your health history with you, assess your heart and lungs, and discuss medication options to assist with Smoking Cessation. This appointment must occur before the first group meeting.

In Person: Frankie Tai
Room 242, Infirmary Building
Student Health Care Center
1 Fletcher Drive

By Fax: ATTN: Frankie Tai
(352) 846-1030

By email: frankiet@ufl.edu

Medication History:
List all prescription and nonprescription medications you currently take including Vitamins and Herbal Supplements by name, dosage and frequency.

Drug/Product Name	Dosage	Frequency

Health History:
Are you receiving treatment now, have your received treatment in the past, or have you ever had a problem with any of the following health concerns:

Yes / No - If **Yes**, when? Use as many lines to describe as needed:

_____ Allergies to medications/Foods _____

_____ Allergic Rhinitis _____

_____ Anxiety _____

_____ Asthma _____

_____ Chronic Pain _____

_____ Depression _____

_____ Gastrointestinal Disorders _____

_____ Pulmonary Disease _____

_____ Hospitalizations/Surgeries _____

_____ Heart Disease _____

_____ Hypertension _____

_____ Immunosuppression _____

_____ Kidney Disease _____

_____ Liver Disease _____

_____ Other Psychiatric Disorders _____

_____ Seizures _____

_____ Sleep Disorder _____

_____ Substance Abuse _____

_____ Any Other: _____

I attest that the medical information I have provided above is accurate and complete.

Patient Signature: _____ Date: _____

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I give permission for my primary medical provider/personal physician to be contacted about my participation in UF's Smoking Cessation Program.

Signature: _____ Date: _____

Medical Provider's Name: _____

Local Address: _____

_____

Phone Number: _____ Fax Number: _____