Name:_____ Birthdate: _____/_____/_____

Thank you for choosing to establish your primary medical care at our practice. We would like to know what concerns bring you here today.

_____

_____

If painful – on a scale of 1 – 10 (with one being minimal pain and 10 being the worst possible pain), how much pain are you in?

1 2 3 4 5 6 7 8 9 10

Medical History	**<u>Circle</u> what personally applies to you**	
1. Head, Eye, Ear, Nose, Throat	Seasonal Allergies Hard of Hearing	Glaucoma Cataracts
2. Respiratory	COPD Asthma	Pulmonary Embolism TB
3. Cardiovascular	Angina Heart Attack Angioplasty/Stent High Cholesterol Hypertension Arrhythmia / AFib	Pacemaker Heart Murmur Leg/Foot Ulcers Peripheral Vascular Disease
4. Gastrointestinal	Heartburn/Reflux Ulcers Barret's Esophagitis Hiatal Hernia	Liver Disease / Hepatitis Diverticulitis GI Bleed
5. Genitourinary	Urinary Infections Kidney Disease Kidney Stones	Dialysis Enlarged Prostate Urinary Incontinence
6. Musculoskeletal	Osteoarthritis Back Problems/Pain	Rheumatoid Arthritis Osteoporosis Gout
7. Neurological	Headache Parkinson's	Unsteady Walking Seizure Disorder
8. Endocrine – Metabolic	Diabetes Hypothyroid	Hyperthyroid Goiter
9. Blood – Lymphatic	Bleeding Disorder HIV or AIDS Leukemia Blood Clots (DVT) Anemia	Cancer: (Type)

10. Dermatological	Changing Moles Psoriasis	Eczema
11. Psychiatric	Depression Bipolar	Anxiety Addiction
12. Allergy	Hives Itching	
13. Other		

Surgery	Approx Date

Medications:
Please note that we participate in the Florida Medicine Database program. This means that we will regularly be reviewing your medications on <u>each</u> visit.
Please bring your bottles to each visit.

Name of Medication	Dosage	How often (Once Twice etc)	Time of Day (AM / PM / Lunch / Dinner ect.)
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			

Do you take any of these over the counter medications: (circle)

Aspirin 81 mg or 325mg	Fish Oil
Vitamin D	B12
Calcium	Red Yeast Rice

Vaccine History:

Vaccine Name	**Age Group**	**Frequency**	**Approx date received**	**Do you need or want one**
Flu Shot	Everyone	Annually		Y / N
Tetanus	Everyone	Every 10 years		Y / N
Pneumonia	60 and above	At least once		Y / N
Shingles	60 and above	Once		Y / N
Meningicoccal	18-30	Once		Y / N
Guardisil	18-26	Series		Y / N

Allergies:
Please list all Allergies with severe reactions such as, swelling of the face or throat, hives, rash, blisters etc.

Name of medication	Reaction
1.	
2.	
3.	
4.	

Social History/Wellness:

Procedure	**Approx Date**	**Result**
Colonoscopy		
PSA		
Rectal Exam		
EKG		
Stress Test		
Echo		
Carotid Ultrasound		
Mammogram		
PAP		
Bone Density Scan		

Occupation: _____ Marital Status: _____
Smoking Status: Never Smoked Former smoker & Quit date _____
How many packs/day? _____
Chewing Tobacco? _____
Alcohol Intake: Number per week _____
Has anyone ever told you to cut down on your drinking? _____
Caffeine Intake: Number per day _____
Do you use drugs for non-medical reasons? Y N
If yes, Please list: _____

Advanced Directives (legal documents)
Do you have a Advanced Directives? Y / N

Family History (blood relatives): Adopted (circle)

	Heart Disease	High Blood pressure	High Cholest-erol	Stroke	Diabetes	Kidney Disease	Cancer
Mom							
Dad							
Siblings							

If Deceased	Age at Death	Cause
Mother		
Father		
Siblings		

Other Physicians (Specialists) involved in your care and their specialty:
1.
2.
3.

Your preferred pharmacy (Mail order and/or local). Do you prefer 30 day or 90 day Rx?