PLEASE ANSWER ALL QUESTIONS & PRINT CLEARLY		
PATIENT INFORMATION:		PT CHART #(OFFICE USE ONLY)
FAMILY/LAST NAME:	FIRST NAME:	
PERMANENT ADDRESS:		
CITY:	STATE:	ZIP CODE:
HOME PHONE: ( ) -	SOCIAL SECURITY #:	
CELL/OTHER PHONE: ( ) -	EMAIL ADDRESS:	
DATE OF BIRTH: / / AGE:	SEX: M / F	MARITAL STATUS:
PRIMARY LANGUAGE:	ETHNICITY:	
Medical Reason For Visit Today:		
Patient Employed? Yes / No	Occupation:	
Employer Name:	Work Telephone: ( ) -	
Do you have and Advanced Directive? Yes / No *Please select one		
Would you like to receive Advanced Directive –Living Will Form? Yes / No *Please select one		
<u>EMERGENCY CONTACT INFORMATION</u>	**<u>RELATION :</u>**	
NAME:	**PHONE NUMBER: ( ) -**	
INSURANCE INFORMATION		
INSURANCE NAME:		
POLICY NUMBER:	GROUP NUMBER:	
***(IF VISITING) LOCAL FLORIDA ADDRESS**		
Street :	City:	Zip Code:
Local Phone Number: ( ) -		
Signature of patient/or/authorized person		Date:
<u>How did you hear about us?</u> Friend Internet Yellow/White Pages Drive By Insurance Company Other		

ADULT PATIENT HISTORY

Name: ____Occupation:____________________________
Date of birth:___/___/_____ Marital Status:________________________Number of children:______________

Medications: *Please include prescriptions, over the counter, vitamins, herbs, supplements:*

Name	Dose	Name	Dose

Allergies: *To medications, X-ray dyes, latex, food, other:* □ *Yes* □ *No* *If YES, please list:*

Medical allergies:______________________________ Food/other allergies:________________________________

Past medical history

Please place a check beside disease and symptoms you have experienced in the past or are presently experiencing.

□High blood pressure
□Diabetes
□Heart disease
□Blocked arteries
□Skips or rapid rate
□Murmur/valve problems
□Heart failure
□High cholesterol
□Cancer
Type: ________________
□Thyroid disease
Type:________________
□COPD
□Asthma
□Pneumonia
□Nasal allergies
□Neck pain
□Low back pain
□Arthritis
Type: ________________
□Gout
□Kidney stones
□Kidney disease
Type: ________________
□BPH
□Urinary tract infection
□Venereal disease
Type:________________
□Hepatitis or jaundice
Type:________________
□Hemorrhoids
□Colitis
Type:________________
□GERD (heartburn/indigestion)
□Peptic ulcer disease
□Gall bladder disease
□Anemia
□Blood disorder
Type:________________
□Skin disease
□Acne
□Psoriasis
□Eczema
□Other:______________
□Varicose veins
□Poor circulation
□Migraine headaches
□Glaucoma
□Macular degeneration
□Fibromyalgia
□Chronic fatigue syndrome
□Depression/suicidal thoughts
□Anxiety/panic
□Alcohol abuse
□Drug abuse
□Neck or head radiation
□Hot flashes/ night sweats
Fever
□Cold or heat intolerance
□Excessive thirst or urination
□Unexplained weight gain/loss
□Swollen glands
□Easy bruising/bleeding
□Fatigue
□Dizziness/light-headedness
□Headaches
□Loss of vision/blurred vision/double vision
□Hearing loss
□Ringing in ears
□Nose bleeds
□Nasal congestion
□Hoarseness/ sore throat
□Swallowing problems
□Cough
□Wheezing
□Shortness of breath
□Chest pain tightness
□Heart skipping/ pounding
□Abdominal pain/discomfort
□Nausea/vomiting
□Constipation
□Diarrhea
□Change in bowel habits
□Blood in/on bowel movements
□Frequent urination
□Difficulty urinating
□Burning/pain with urination
□Blood in urine
□Difficulty controlling BM
□Penile discharge
□Difficulty with erections
□Joint pain/swelling
□Foot/ankle swelling
□Rash
□Changing mole
□Skin lump or sore
□Irritability/mood swings
□Weakness
□Numbness/tingling sensation
□Balance problems
□Poor concentration/focus on task
□Memory loss
□Recent falls

Patient's Name: ____ DOB: ____________________________

Gynecologic and obstetric history

Age at onset of periods: ______________________Frequency:____________________Length of period:________

Number of each: Pregnancy:_____________Births:_________Miscarriages:___________Therapeutic abortions:___

Please place a check beside symptoms you have experiences or are presently experiencing. Provide a brief description; including dates

Prolonged/abnormal bleeding__________________________________Abnormal discharge____________________

Leakage of urine____History of abnormal pap smear___________

Pelvic pain____ ______________________________

Immunization history

Have you had immunization for:

Tetanus ☐No ☐Yes When:_________ Hepatitis B ☐No ☐Yes When:_________

Pneumonia ☐No ☐Yes When:_________ List any other immunizations with dates:___________

Shingles ☐No ☐Yes When:_________ ______________________________

Preventative tests

When did you last have the following tests:

Pap smear _______________ Breast exam _______________ Stool check for blood ____

Mammogram _______________ Colonoscopy _______________ Prostate exam _____

Bone mineral density _______________ Cholesterol check____________

Family History

Has any member of your family (parents, grandparents, or other siblings) have been diagnosed with the following:

Illness	**Family member(s)**	**Approximate age when diagnosed**
Cancer		
Type:_______________	_______________	_______________
Type:_______________	_______________	_______________
Type:_______________	_______________	_______________
Hypertension (High blood pressure)	_______________	_______________
Heart disease	_______________	_______________
High Cholesterol	_______________	_______________
Diabetes	_______________	_______________
Stroke	_______________	_______________
Mental Disease (anxiety, depression)	_______________	_______________
Drug Addiction	_______________	_______________
Alcohol addiction	_______________	_______________
Glaucoma	_______________	_______________
Bleeding disease	_______________	_______________
Arthritis	_______________	_______________
Type:_______________	_______________	_______________

Patient's Name: ____ DOB: ___________________________

Family History Cont'd

Kidney problems ____________________________________ _______________
Asthma ____________________________________ _______________
Hereditary disease ____________________________________ _______________
____ _______________

Preventive lifestyle

Do you wear seatbelts? □ No □ Yes If no, why? ____________________ ________

Do you wear a bike helmet? □ No □ Yes If no, why? ____________________ ________

Do you exercise regularly? □ No □ Yes If yes, what kind, duration, times per week?

____ ________

Are you on a special diet? □ No □ Yes If yes, what kind, _______________ ________

Do you smoke? □ No □ Yes If yes, how many packs per day?___ ________

Do you drink caffeinated beverages? □ No □ Yes If yes, how many cups per day? ___ ________

Do you drink alcoholic beverages? □ No □ Yes If yes, how many drinks per day? __ ________

If there is a gun in the house, is it un-loaded and out of children's reach? □ No □ Yes □ Does not apply

Do you use drugs (marijuana, cocaine, crack, etc.)? □ No □ Yes If yes, explain: _________________ ________

Have you engaged in activity that has put you at risk for AIDS? □ No □ Yes If yes, explain: _________________ ________

Have you ever worked with chemicals, paint, asbestos, or other hazardous materials? □ No □ Yes If yes, explain: _________________ ________

Are you in a relationship in which you have been physically hurt (slapped, kicked, punched, bruised) by our partner? □ No □ Yes □ Does not apply

Do you ever feel afraid of your partner? □ No □ Yes □ Does not apply

Do you have an organ donor card? □ No □ Yes

Do you use birth control? □ No □ Yes If yes, which method? ___________ ________

Patient's Signature: ______________________ Date:_________ Reviewed by physician____________________ Date:________