1132 Cypress Glen Circle Kissimmee, FL 34741 * **Phone:** 407-343-4700 * **Fax:** 407-343-8500

Date _____ D.O.B. _____ Age _____ Patient Name _____

PAST MEDICAL HISTORY (Have you had these?) Please do a checkmark (√).

Yes	No		Yes	No		Yes	No	
___	___	High Blood Pressure	___	___	Peptic Ulcer	___	___	Arthritis
___	___	Gallbladder Disease	___	___	Diabetes	___	___	Bowel/Colon disorder
___	___	Pneumonia	___	___	Liver disease	___	___	Thyroid disease
___	___	Kidney stones	___	___	High cholesterol	___	___	Kidney disease
___	___	Asthma/emphysema	___	___	Stroke	___	___	Heart disease
___	___	Epilepsy/seizures	___	___	Bleeding disorder	___	___	Cataracts
___	___	Radiation treatment	___	___	Gout	___	___	Tuberculosis
___	___	Anemia	___	___	Cancer	___	___	Bladder infections/UTI
___	___	Glaucoma	___	___	Depression	___	___	Psychiatric disorder
___	___		___	___		___	___	

FAMILY MEDICAL HISTORY (Have any blood relative ever had?) Please do a checkmark (√).

Yes	No		Who	Yes	No		Who
___	___	Diabetes	_____	___	___	Cancer	_____
___	___	Thyroid disease	_____	___	___	Hepatitis	_____
___	___	High blood pressure	_____	___	___	HIV	_____
___	___	Heart disease	_____	___	___	Abnormal bleeding	_____
___	___	High cholesterol	_____	___	___	Dementia	_____
___	___		_____	___	___		_____

SOCIAL HISTORY. Please do a checkmark (√).

Married ____ Single ____ Divorced ____ Widowed ____ Separated ____

Have you used tobacco? Yes___ No___ # of packs/day _____ For how many years? _____
Have you used alcohol? Yes___ No___ How much/daily_____ For how many years? _____
Have you used any drugs? Yes___ No___ What kind? _____ For how many years? _____

- If yes, have you ever received any counseling or entered a Rehab. Program.
- Program Name/Location Date
- _____

Do you use caffeine? Yes___ No___ Coffee/day _____ Cola/day _____ Tea/day _____
Do you exercise regularly? Yes___ No___ Are you on a regular diet? _____
Is sex satisfactory? Yes___ No___ Recent changes in sex life? _____

LIST OF CURRENT MEDICATIONS

Name of Medication	Dose/ frequency	Reason for taking medication
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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D.O.B. _____ Patient Name _____

ALLERGIES: Yes ____ No ____ Medications: Penicillin ____ Sulfa _____ Aspirin _____
Any other allergies? _____

PREVIOUS SURGICAL HISTORY

_____ Date_____ _____ Date _____
_____ Date_____ _____ Date _____

REVIEW OF SYSTEMS (In last 6 months) Please do a checkmark (√).

GENERAL

Weight change	Yes___	No___
Extreme fatigue	Yes___	No___
Fainting	Yes___	No___
Dizziness	Yes___	No___
Excessive brusing	Yes___	No___
Impaired sight	Yes___	No___
Nose bleeds	Yes___	No___
Anxiety	Yes___	No___

SKIN

Dry	Yes___	No___
Moist	Yes___	No___
Rash	Yes___	No___
Normal	Yes___	No___
Open wounds	Yes___	No___

CARDIAC/RESPIRATORY

Shortness of breath	Yes___	No___
Chest pain	Yes___	No___
Heart palpitations	Yes___	No___
Persistent cough	Yes___	No___
Edema	Yes___	No___

GASTROINTESTINAL

Ulcers	Yes___	No___
Liver disease	Yes___	No___
Diarrhea	Yes___	No___
Constipation	Yes___	No___
Blood in stool	Yes___	No___
Nausea/vomiting	Yes___	No___

NEUROLOGICAL

Severe headaches	Yes___	No___
Confusion	Yes___	No___
Tingling	Yes___	No___
Numbness	Yes___	No___

ENDOCRINOL.

Excessive thirst	Yes___	No___
Increased urination	Yes___	No___
Rising to void more than once a night	Yes___	No___

FEMALE REPRODUCTIVE

Age of menstruation ____ Is it regular? Yes___ No___
No. of pregnancies _____ Children born alive _____
Date last menstrual period _____
Date of last pap-smear_____
Last breast exam _____

MALE REPRODUCTIVE

Prostate problems	Yes___	No___
Testicular Mass	Yes___	No___
Impotence	Yes___	No___

If taking any medications for impotence list below:
_____

KIDNEYS

Stones	Yes___	No___
Kidney infections	Yes___	No___
Bladder infections	Yes___	No___
Blood in urine	Yes___	No___

VACCINATIONS

PNEUMONIA	YES___	NO____
TETANUS (last 10 yrs)	YES___	NO____
FLU	YES___	NO____

Completed by: Patient_____ Office nurse/M.A_____Physician_____
Patient Signature _____ Date reviewed by Md with patient
____/____/_____Physician Signature _____