# Medical History Form

Patient Name: _____ Date of Birth: _____

**MEDICAL HISTORY.**
**Please check if you have ever had any of the following diseases or conditions?**

Cardiovascular
- None [ ]
- High blood pressure [ ]
- Pacemaker [ ]
- Defibrillator [ ]
- Atrial Fibrillation [ ]
- Stroke [ ]
- Blood clots [ ]
- High Cholesterol [ ]
- Coronary artery disease
  - Heart Attack [ ]
  - Stent [ ]
- Other _____ [ ]

Respiratory
- None [ ]
- Emphysema/COPD [ ]
- Asthma [ ]
- Other _____ [ ]

Gastrointestinal/Genitourinary
- None [ ]
- Reflux/GERD [ ]
- Enlarged Prostate/BPH [ ]
- Kidney failure [ ]
- Other _____ [ ]

Endocrine
- None [ ]
- Diabetes [ ]
- Hyperthyroidism [ ]
- Hypothyroidism [ ]
- Other _____ [ ]

Head/Eyes/Ear/Nose/Throat
- None [ ]
- Cataracts [ ]
- Glaucoma [ ]
- Hearing Loss [ ]
- Other _____ [ ]

Cancers
- None [ ]
- Breast [ ]
- Ovarian [ ]
- Lung [ ]
- Colon [ ]
- Prostate [ ]
- Bladder [ ]
- Leukemia [ ]
- Lymphoma [ ]
- Other _____ [ ]

Cancer Treatment
- None [ ]
- Radiation [ ]
- Chemotherapy [ ]

Psychiatric/Neurologic
- None [ ]
- Epilepsy/seizure disorder [ ]
- Alzheimer's [ ]
- Parkinson's [ ]
- Depression [ ]
- Bipolar disorder [ ]
- Anxiety [ ]
- Other _____ [ ]

Musculoskeletal
- None [ ]
- Arthritis
  - Rheumatoid [ ]
  - Osteoarthritis [ ]
- Artificial joint [ ]
- Fibromyalgia [ ]
- Other _____ [ ]

Infections
- None [ ]
- MRSA [ ]
- HIV / AIDS [ ]
- Tuberculosis [ ]
- Hepatitis: A / B / C

**SURGICAL HISTORY. Please list any surgeries you have had:**

Heart:
- [ ] Stent
- [ ] Bypass
- [ ] Valve Replacement
- [ ] Transplant

Joint Replacement:
- Hip [ ] Right [ ] Left [ ] Both
- Knee [ ] Right [ ] Left [ ] Both
- Shoulder [ ] Right [ ] Left [ ] Both
- Other [ ] _____

- [ ] Appendix Removed
- [ ] Bladder Removed
- [ ] Spleen Removed

Breast:
- [ ] Biopsy
- [ ] Mastectomy
- [ ] Lumpectomy
  - [ ] Right [ ] Left [ ] Both
- [ ] Implants

Kidney:
- [ ] Biopsy
- [ ] Transplant

Prostate:
- [ ] Removed
- [ ] Biopsy
- [ ] TURP

Colon: Colectomy
- [ ] Diverticulitis
- [ ] Colon Cancer Resection
- [ ] IBD

Liver:
- [ ] Transplant

Skin Cancer:
- [ ] Squamous Cell Carcinoma
- [ ] Basal Cell Carcinoma
- [ ] Melanoma

Ovaries: Removed
- [ ] Endometriosis
- [ ] Cancer
- [ ] Cyst

Hysterectomy
- [ ] Fibroids
- [ ] Cancer

**SKIN HISTORY. Please check if you have ever had any of the following diseases or conditions?**

[ ] None [ ] Eczema [ ] Basal Cell Carcinoma
[ ] Psoriasis [ ] Blistering Sunburns [ ] Precancerous Moles / Dysplastic Nevus
[ ] Rosacea [ ] Actinic Keratosis [ ] Melanoma [ ] Acne
[ ] Hay Fever / Allergies [ ] Squamous Cell Carcinoma [ ] Other _____

Do you wear sunscreen? Yes / No

What SPF? _____

Do you tan in a tanning salon? Yes / No

Family history of Melanoma: Yes / No

[ ] Mother [ ] Father [ ] Brother [ ] Sister [ ] Daughter [ ] Son
[ ] Grandmother [ ] Grandfather [ ] Aunt [ ] Uncle

**Medication: List any medications you are taking (including prescriptions, over-the-counter, herbals, vitamins and creams):**

| Name | Strength | How Often | Reason |
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**Are you allergic to any medications: Yes / No**
**If yes, please list:** _____

Allergy to adhesive? YES NO
Allergy to epinephrine? YES NO
Allergy to latex? YES NO
Allergy to lidocaine? YES NO

**Do you take antibiotics before any kind of procedures?** YES NO

**Do you have a history of MRSA?** YES NO

When: _____ Where? _____

**OTHER INFORMATION**

Are you a: FORMER SMOKER CURRENT SMOKER NEVER SMOKER

Do you drink alcohol? YES NO If so, how often? _____

Hobbies: _____

How often do you exercise? _____

Caffeine use: ONCE DAILY SEVERAL TIMES A DAY FEW TIMES A WEEK NEVER

Occupation: _____

Year-round Florida resident? YES NO If not, where else do you live? _____

**QUALITY MEASURES:**

Have you received a Pneumonia vaccination? Yes / No
Have you received an Influenza vaccination? Yes / No
Are you interested in the Patient Portal? Yes / No

Family Medical History:
What is your family medical history?

Mother: _____ Father: _____

Brother: _____ Sister: _____

Daughter: _____ Son: _____

**REVIEW OF SYSTEMS.**
**Please check if you are currently experiencing any of the following symptoms?**

Cardiovascular
- Chest pain [ ]
- Palpitations [ ]
- Other _____ [ ]

Respiratory
- Shortness of breath [ ]
- Cough [ ]
- Other _____ [ ]

Head/Eyes/Ear/Nose/Throat
- Change in vision [ ]
- Ringing in ears [ ]
- Sore throat [ ]
- Headache [ ]
- Other _____ [ ]

Gastrointestinal/Genitourinary
- Abdominal pain [ ]
- Nausea/vomiting/diarrhea [ ]
- Pain with urination [ ]

Musculoskeletal
- Joint pain [ ]
- Muscle pain [ ]
- Muscle weakness [ ]
- Other _____ [ ]

Systemic
- Fever/chills/night sweats [ ]
- Unexplained weight loss [ ]
- Other _____ [ ]

Psychiatric/neurologic
- Depression [ ]
- Anxiety [ ]
- Numbness/tingling [ ]
- Other _____ [ ]

_____

PATIENT SIGNATURE (or name of person completing this form) DATE