MEDICAL HISTORY

NAME _____ AGE _____ DATE OF BIRTH _____

DATE FORM FILLED OUT _____ HEIGHT _____WEIGHT _____

NOTE: Please, fill out and bring to your first appointment. This is a confidential part of your medical history and will be kept in our office as a permanent part of your chart. All the information contained in this form in all the three pages will not be released to any person or entity without your written authorization as mandated by HIPPA.

YOUR PRIMARY CARE PROVIDER IS : _____

Past Medical History

Please, list all your Medical Problems

Diagnosis	Date	Doctor
➢ _____		
➢ _____		
➢ _____		
➢ _____		
➢ _____		
➢ _____		
➢ _____		
➢ _____		
➢ _____		
➢ _____		

Past Surgical history

Please, list all the operations you have had in the past.

Type	Date	Surgeon	Complications if any
➢ _____			
➢ _____			
➢ _____			
➢ _____			
➢ _____			
➢ _____			
➢ _____			

MEDICATIONS: Please fill the attached form.

Please, list all your prescription medications and all over the counter medications, especially arthritis medications, such as NSAIDS, herbal medications (AMTs "alternative medical therapies") or natural remedies.

Patient's name: _____ Sign and date: _____

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504 North MacArthur Avenue, Panama City, Florida 32401-3636

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FAMILY HISTORY If Living If deceased

Current age Health Age at death Cause of death

Father: _____

Mother: _____

Brothers or Sisters: _____

_____

Children: _____

_____

Has any of your immediate blood relative ever had: Check if **YES? Who**_____

Cancer _____ Heart Disease _____ Sickle Cell Disease _____ Congenital Deformities _____

Diabetes_____ Stroke_____ Kidney disease_____ Dialysis_____ High Blood pressure _____

Polycystic Kidney Disease_____OTHER _____

SOCIAL HISTORY – Present occupation _____

If retired, previous occupation_____

Married_____ I live Alone_____

Single_____ I live with someone who can care for me _____

Widowed_____ I live with someone who is unable to care for me _____

Divorced _____ I live alone but have friends or family that can care for me _____

HABITS

Smoking
1. I do not smoke and have never smoked. _____
2. I do not smoke now but used to smoke. _____ Packs per day. _____
   How many years _____ Date you quit _____
3. I presently smoke. _____ Packs per day_____ for how many years _____

Alcohol	1. Do you consume alcoholic beverages now?	Prefer not to answer	Yes	No
	2. Have you ever had a "drinking" problem?	Prefer not to answer	Yes	No
Drugs	1. Do you use recreational drugs now?	Prefer not to answer	Yes	No
	2. Have you ever used recreational drugs?	Prefer not to answer	Yes	No

MILITARY HISTORY and FOREIGN TRAVEL

- _____

Have you ever taken arthritis medication for a long period of time?_____

ALLERGIES: Please circle any medications to which you are allergic:

- Penicillin Sulfa Aspirin Iodine Latex Allergy Tape Shell fish or seafood ACE-Inhibitors
- Describe the reaction :_____

Please list **ANY** substance to which you are allergic not mentioned above, and describe the reaction.

Do you want to tell us anything we have not asked?

_____

Patient's name: _____ Sign and date: _____

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REVIEW OF SYSTEMS – Please, answer **YES** if you **currently** have or have **ever** had the following:

Problem	Yes	No	**Problem**	Yes	No
Recent unintentional weight changes			Stomach ulcers or pains		
Spots before eyes, Diabetic eye disease			Jaundice		
Blurred, double vision or Glaucoma			Hiatal hernia		
Poor hearing or ringing in ears			Reflux or heart burns		
Mouth sores, ulcers or thrush			Intestinal Bleeding		
Difficulty swallowing			Nausea or vomiting		
Nosebleeds			Diverticulitis		
Frequent or severe headaches			Hemorrhoids		
Sinus trouble or hoarseness			Bloody or black tarry Stools		
Coughing up blood			Hepatitis		
Pleurisy			History of internal bleeding		
Bronchitis or emphysema			Gallbladder Problems		
Asthma or wheezing			Colitis		
Swelling in your legs			Constipation		
Shortness of breath			Diarrhea		
Chest pains or angina			Lose urine on coughing or sneezing		
Dizziness or fainting spells			Kidney Stones		
Persistant Cough			Difficulty starting urine		
Heart Attacks			Blood in urine		
Wake up at night short of breath			Trouble emptying bladder		
Leg cramps on walking			Dribbling at the end of urination		
Irregular Heartbeat, palpitations			Back Pains		
Heart Failure			Wake up at night to urinate, how many times		
Heart Murmur			Fevers or night sweats		
Previous blood transfusion			Enlarged glands or lymph nodes		
Poor appetite			Easy bruising		
Snoring			Skin rashes		
Anemia			AIDS or HIV Positive		
Blood Clot in legs or lungs			Psoriasis		
Epilepsy or seizures			Skin Problems		
Tingling in feet and hands			Changes in hair		
Stroke			Arthritis		
Mental Illness			Joint swelling		
Depression			Muscle aches		
Memory Loss			Joint pains		
Tremors or falls			Gout or Lupus		
Diabetes or Thyroid disease			**OTHER:**		

Patient's name: _____ Sign and date: _____

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NAME: _____ DOB: _____ DATE: _____

MEDICATION NAME	STRENGTH	HOW YOU TAKE	PRESCRIBING PHYSICIAN