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.

PATIENT HEALTH INFORMATION SHEET

NAME: _____ DATE OF BIRTH: _____ AGE:_____

ADDRESS: _____ PHONE:_____

INSURANCE: _____

PRIMARY CARE PHYSICIAN: _____

REFERRING PHYSICIAN: _____ SURGEON (IF APPLICABLE): _____

PAST & CURRENT MEDICAL PROBLEMS

1._____ **6. _____**

2. _____ **7. _____**

3. _____ **8. _____**

4. _____ **9. _____**

5. _____ **10. _____**

HOSPITALIZATIONS & OPERATIONS (APPROXIMATE DATES & LOCATIONS)

1. _____

2. _____

3. _____

4. _____

5. _____

YOUR MEDICATION RECORD

Date: _____

Name: _____DOB:_____Phone:_____

Address:_____

_____

E-mail:_____

Primary Dr:_____

Allergies and reactions caused:_____

_____

Have you had a Flu shot? ____Yes ____No When _____

Have you had a Pneumonia shot? ___Yes ___No When _____

List your medicines, herbal, vitamins/supplements and over the counter medicines

Medication Name	Dose	Frequency

Your preferred pharmacy is:_____ Store #:_____

Street Address:_____ City:_____

Phone Number: _____

By signing this you are consenting to participate in electronic prescribing, which allows the doctors access to your pharmacy and prescription information.

X_____

FAMILY HISTORY

FAMILY MEMBER	AGE	HEALTH PROBLEMS	IF DECEASED/AGE & CAUSE OF DEATH
FATHER			
MOTHER			
HOW MANY SISTERS?			
HOW MANY BROTHERS?			
CHILDREN (F/M)			
(F/M)			
(F/M)			
(F/M)			

ANY FAMILY MEMBER WITH CANCER OR BLOOD PROBLEM?

RELATIONSHIP: _____CANCER TYPE/BLOOD PROBLEM:_____

RELATIONSHIP: _____CANCER TYPE/BLOOD PROBLEM:_____

SOCIAL HISTORY

CIRCLE ONE: SINGLE MARRIED DIVORCED WIDOWED

PLACE OF BIRTH:_____
PERMANENT RESIDENCE:_____
YOUR CURRENT OR PREVIOUS OCCUPATION:_____
SPOUSE'S AGE & CURRENT OR PREVIOUS OCCUPATION:_____
HOW MANY YEARS IN FLORIDA:_____

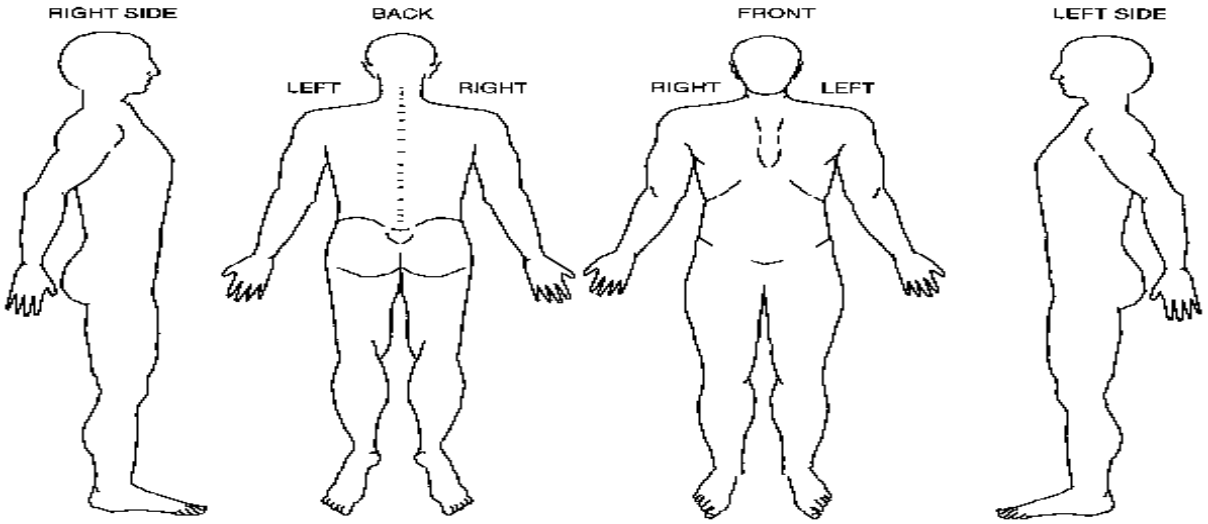
EVER USE TOBACCO? YES NO
WHAT TYPE? CIGARETTES CIGAR PIPE OTHER
HOW MUCH?_____ HOW LONG?_____
WHEN QUIT?_____

EVER DRINK ALCOHOL? YES NO
CURRENT PAST
HOW MUCH?_____ _____
HOW FREQUENT? _____ _____
EVER 6 OR MORE DRINKS ON ONE OCCASION? YES/NO _____

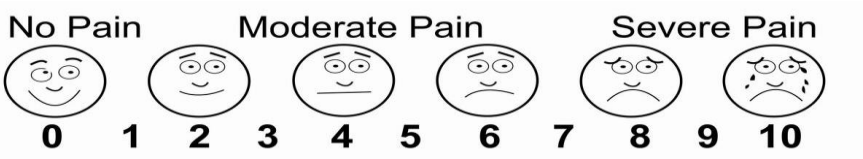
EVER EXPOSED TO RADIATION, TOXINS, CHEMICALS OR ASBESTOS? YES NO
WHEN & WHERE? _____
_____

SYSTEMIC REVIEW

PAIN ASSESSMENT



CHOOSE THE FACE THAT BEST DESCRIBES HOW YOU FEEL



PLEASE CIRCLE YES OR NO IF EVER HAD PROBLEM OR IS A CURRENT PROBLEM.

HEMATOLOGIC:

BLOOD DISEASE	NO	YES
ANEMIA	NO	YES
DIFFICULTY HEALING	NO	YES
SWOLLEN LYMPH GLANDS	NO	YES
BLOOD CLOTS	NO	YES
PLATELET PROBLEMS	NO	YES
ABNORMAL BRUISING	NO	YES
ABNORMAL BLEEDING	NO	YES
HEAVY SURGICAL BLEEDING	NO	YES
HEAVY NASAL BLEEDING	NO	YES
HEAVY GUM BLEEDING	NO	YES
BLOOD TRANSFUSIONS	NO	YES

HOW MANY? _____ WHEN _____

IMMUNITY:

FREQUEST COLDS	NO	YES
ALLERGIES TO DUST/POLLEN	NO	YES
SERIOUS INFECTIONS	NO	YES
IMMUNE DISORDER AIDS/HIV	NO	YES
AUTOIMMUNE DISEASE	NO	YES

COMMENTS: _____

_____

EMOTIONAL:

SEEN A PSYCHIATRIST	NO	YES
DEPRESSION	NO	YES
THOUGHTS OF SUICIDE	NO	YES
SLEEP TROUBLE	NO	YES
APPETITE CHANGE	NO	YES
ANXIETY ATTACKS	NO	YES

GYNECOLOGICAL:

HEAVY PERIODS	NO	YES

APPROX. AGE PERIOD STARTED: _____

APPROX. LAST PERIOD: _____

NUMBER OF PREGNANCIES: _____

MISCARRIAGES OR ABORTIONS: _____

DATE OF LAST PAP SMEAR: _____

DATE OF LAST MAMMOGRAM: _____

BREAST SELF EXAMS	NO	YES

PLEASE CIRCLE YES OR NO IF EVER HAD PROBLEM OR IS A CURRENT PROBLEM.

GENERAL:

HEALTH GOOD?	NO	YES
RECENT WEIGHT CHANGE	NO	YES
UNEXPLAINED FEVERS	NO	YES
NIGHT SWEATS	NO	YES
SLEEP TROUBLE	NO	YES
CHANGE IN APPETITE	NO	YES

SKIN:

SKIN PROBLEMS	NO	YES
DO YOU USE SUNSCREEN	NO	YES
RASH	NO	YES
SKIN CANCER	NO	YES
SKIN EXAMS	NO	YES

HEAD & NECK:

CATARACTS	NO	YES
GLAUCOMA	NO	YES
SINUS TROUBLES	NO	YES
HOARSENESS	NO	YES
EAR/HEARING TROUBLE	NO	YES
TROUBLE SWALLOWING	NO	YES

ENDOCRINE:

THYROID PROBLEMS	NO	YES
DIABETES	NO	YES
BIRTH CONTROL PILLS	NO	YES
ESTROGEN REPLACEMENT	NO	YES

RESPIRATORY:

PNEUMONIA	NO	YES
TUBERCULOSIS	NO	YES
COUGHING BLOOD	NO	YES
CHRONIC COUGH	NO	YES
ASTHMA	NO	YES
EMPHYSEMA	NO	YES
SHORTNESS OF BREATH	NO	YES

CARDIOVASCULAR:

HEART ATTACKS	NO	YES
CHEST PAIN/ANGINA	NO	YES
HIGH BLOOD PRESSURE	NO	YES
LEG SWELLING	NO	YES
SLEEP APNEA/SNORING	NO	YES
RHEUMATIC FEVER	NO	YES
ABNORMAL RHYTHM	NO	YES
ABNORMAL CHOLESTEROL	NO	YES

GASTROINTESTINAL:

CONSTIPATION	NO	YES
DIARRHEA	NO	YES
VOMITING	NO	YES
VOMITING BLOOD	NO	YES
ULCER	NO	YES
RECTAL BLEEDING	NO	YES
GALLBLADDER TROUBLE	NO	YES
HEPATITIS/JAUNDICE	NO	YES
HEARTBURN	NO	YES
BLACK STOOL	NO	YES
CHANGE IN BOWEL HABITS	NO	YES
PENCIL SHAPE STOOLS	NO	YES
CRAMPING	NO	YES
HEMORRHOIDS	NO	YES

DATE OF LAST COLONOSCOPY: _____

GENITOURINARY:

LOSS OF URINE	NO	YES
FREQUENT URINATION	NO	YES
BURNING URINATION	NO	YES
BLOOD IN URINE	NO	YES
PAINFUL URINATION	NO	YES
KIDNEY PROBLEM	NO	YES
KIDNEY STONES	NO	YES
DIALYSIS	NO	YES
DO YOU GET A ROUTINE PSA	NO	YES

NEUROLOGICAL:

NUMBNESS/WEAKNESS	NO	YES
STROKE OR TIA	NO	YES
SEIZURES	NO	YES
FAINTING SPELLS	NO	YES
PARALYSIS	NO	YES
DIZZINESS	NO	YES
MEMORY LOSS	NO	YES
CONFUSION	NO	YES
HEADACHES/MIGRANES	NO	YES

MUSCULOSKELETAL:

JOINT PAIN	NO	YES
BONE PAIN	NO	YES
ARTHRITIS	NO	YES
GOUT	NO	YES
OSTEOPOROSIS	NO	YES