Internal Medicine

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Florida Medical Clinic

Your Life, Our Specialty

Health Questionnaire

Patient's Name _____ Medical Record # _____ Date _____

HOSPITAL ADMISSIONS/MEDICAL PROBLEMS:

Year	Illness or Operation	Year	Illness or Operation

Medical History: Mark (C) for current problems, indicate with (X) if you have had any of the following symptoms or diseases.

☐ Fever
☐ Chills
☐ Night Sweats
☐ Weight Gain/Loss
☐ Visual Changes
☐ Ear/Hearing Problems
☐ Sinus Trouble
☐ Nose Bleeds *Recurrent*
☐ Hayfever/Allergies
☐ Pneumonia
☐ Cough
☐ Asthma/Wheezing
☐ Shortness of Breath
☐ Exertion ☐ Laying Flat
☐ Chest Pain
☐ High Blood Pressure
☐ Heart Murmur
☐ Rheumatic Fever
☐ Swollen Ankles/Legs
☐ Palpitations
☐ Leg Pain *When Walking*

☐ Varicose Veins
☐ Loss of Appetite *Recent*
☐ Difficulty Swallowing
☐ Heartburn ☐ Ulcer
☐ Nausea/Vomiting
☐ Abdominal Pain
☐ Diarrhea
☐ Constipation
☐ Hepatitis
☐ Bloody or Tarry Stools
☐ Hemorrhoids
☐ Pain/Burning Urinating
☐ Blood in Urine
☐ Sexually Transmitted Diseases
☐ Joint Pain
☐ Osteoporosis
☐ Arthritis
☐ Gout
☐ Rashes
☐ Headaches *Frequent*
☐ Dizzy Spells

☐ Fainting Spells
☐ Numbness/Tingling
☐ Seizures
☐ Stroke
☐ Depression
☐ Nervous
☐ Sleeping Difficulty
☐ Suicidal Thoughts
☐ Feeling Worthless
☐ Diabetes
☐ Thyroid Disease
☐ Heat/Cold Intolerance
☐ Bleeding
☐ Bruising
☐ Anemia
☐ Blood Transfusions
☐ Cancer
☐ Chicken Pox
☐ Polio ☐ Mumps
☐ Measles ☐ Herpes
☐ German Measles

☐ Tuberculosis
☐ AIDS/HIV
☐ Alcohol: Yes / No
How Much? _____
☐ Smoking? _____ cig/day
_____ # yrs Year Quit _____
☐ Exercise: Yes / No
☐ Street Drugs: Yes / No
Which? _____

FEMALES (Month/Year of Last):
Mammogram _____
☐ Normal ☐ Abnormal
PAP Test _____
☐ Normal ☐ Abnormal
Menstrual Flow:
☐ Regular ☐ Irregular ☐ Pain
Days of Flow _____
Length of Cycle _____
Date - 1st day of last period _____

Birth Control Method: _____

Number of:
Pregnancies _____
Abortions _____
Miscarriages _____
Live Births _____

MALE (Month/Year of Last):
PSA: _____

Health Maintenance:
Year of Last Vaccine
Tetanus _____
Influenza _____
Pneumonia _____

Test/Exams (Month/Year of Last):
Full History/Physical _____
Cholesterol _____
Eye Exam _____
Rectal Exam _____
Colonoscopy or flexible sigmoidoscopy _____

MEDICATIONS AND DOSAGE (include those that you buy without prescription): ALLERGIES (include reaction to medicine):

FAMILY HISTORY (if any blood relatives have suffered the following - circle the number and indicate which relative):

1) Epilepsy	6) Thyroid	11) Osteoporosis	16) Hepatitis
2) Migraine	7) Hay Fever	12) Arthritis	17) Alcoholism
3) Mental Illness	8) Asthma	13) Heart Disease	18) High Cholesterol
4) Glaucoma	9) Anemia	14) Stroke	19) Cancer
5) Diabetes	10) Bleed Easy	15) Hypertension	20) _____

_____
_____
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