Florida Medical Clinic
Internal Medicine and Pediatrics
Adult History Form

Name: ______________________________ DOB: ___________________ Gender: M F

Ethnicity: __________________ Email Address: ____

Primary contact number for lab results and appointment confirmation: ______________________________

Preferred Pharmacy location and phone number: ____

MEDICAL HISTORY: Please list any past or current medical problems, including any reasons you may be on medication or hospitalizations

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____
____
____

SURGICAL HISTORY: Please list any surgeries or procedures you have had and dates of procedure

____
____
____

MEDICATIONS: Please list all medications, including vitamins, herbals, Over-the-Counter products

Name	Dose	How Often

Please list all allergies and type of reaction:

____
____
____
____

SOCIAL HISTORY:

Are you currently smoking? Y N If so,how many packs per day? __________ How long? _________

Have you ever smoked?Y N If so,how many packs per day? __________ How long? ___________

Do you drink alcohol? Y N If yes,how much do you drink? ________________________________

Liquor: Per day: ________________ Per week: ________________ Per month: ________________

Beer: Per day: ________________ Per week: ________________ Per month: ________________

Wine: Per day: ________________ Per week: ________________ Per month: ________________

Have you ever had a drinking problem? Y N

Do you use illegal street drugs? Y N If so, please list ________________________________

What is your marital status? ____________ How many children do you have? ____________________

Who lives in your household? ____

What is your occupation? ____

Do you travel outside of the USA? Y N If so, where? _______________________________________

Sexual Orientation: Heterosexual Homosexual Bi-Sexual or prefer not to discuss with provider Do

Do you exercise? ______________ If so, how many times per week? _________________________

FAMILY HISTORY:

	Sex	Age	Deceased	Illnesses
Father: ______ N/A				
Mother: ______ N/A				
Sibling:				
Sibling:				
Children:				
Children:				

GYNECOLOGICAL HISTORY:

Name of GYN: ____

Last Pap: ___________________________ History of abnormal Pap Y N

Number of days in menstrual cycle:__________ Flow: Mild Moderate Heavy

Age of Menopause or Hysterectomy:__________

PREVENTIVE HEALTH HISTORY:

Please indicate the last time the following were performed (or never):

Eye exam and doctor: ____

Podiatrist/Last foot exam: ____

Last dental exam: ____

Last stress test: ______________________ Last EKG: ____________________________

Colonoscopy: _______________________ Stool Occult Blood Testing: _________________

Mammogram: _________________________

Dexa Scan (Bone Density): __________________

Influenza vaccine: _______________________

Tetanus /TDAP vaccine: ___________________

Pneumovax: ___________________________

Prevnar 13: ___________________________

Hep B vaccine: _________________________

Hep A vaccine: __________________________

Zostavax (Shingles) vaccine: _________________

Do you have a living will? __________ If so, please provide a copy with our office.

Do you have Do not resuscitate/Do not intubate? _______________________________________

Emergency Contact: ____

Do you have a Living Will/Advanced Directive? Y N If Yes, please provide a copy with our office.

Signature: ___________________________ Date: ______________________