FLORIDA MEDICAL CLINIC, P.A.
SURGERY
HISTORY & PHYSICAL

Date: _____ Which doctor are you here to see? _____

Patient Name: _____

Referring Physician: _____

Age: _____ Date of Birth: _____ Sex: _____

Chief Complaint: _____

_____

Do you smoke? Y / N How much? _____

Alcohol? Y / N How much? _____

Drug Allergies: Do you have any known allergies to medications, latex, or surgical tape?
Please circle YES or NO. If yes, please list the allergy and the reaction.

1._____ 2._____

3._____ 4._____

Medications: What medications are you currently taking? Include over-the-counter.
If none, please check here: _____

Name	Dosage	Frequency	Name	Dosage	Frequency
1._____			5._____		
2._____			6._____		
3._____			7. _____		
4. _____			8. _____		

Prior Surgery:

1._____ Year: _____

2._____ Year:_____

3._____ Year: _____

4. _____ Year:. _____