Florida Medical Clinic –Family Medicine Temple Terrace

New Patient Medical History

Today’s Date: \_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_ Date of Birth:

Reason for your visit: \_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about us? \_\_\_\_\_ \_\_\_\_\_\_\_

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| **SPECIALISTS** | |
| **Please list any other doctors you see** | **Specialty** |
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| **PERSONAL MEDICAL HISTORY** |

Please mark any conditions that apply to you.

* Anxiety
* Asthma
* Blood/Clotting Disorder
* Cancer \_
* Depression
* Diabetes
* COPD
* Heart Attack:
* Heart Disease
* Heart Failure
* High Blood Pressure
* High Cholesterol
* Kidney Disease
* Osteoporosis
* Stroke
* Thyroid Disease
* Other:

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| **SURGICAL HISTORY** | | | | | | |
| **Please list any surgeries you have had** | | | **Date:** | | | |
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| **FAMILY MEDICAL HISTORY** | | | | | | |
| **Please mark any conditions in your family.** | | | | | | |
|  | Mother | Father | | Brother | Sister | Other |
| Arterial Hardening/blockage |  |  | |  |  |  |
| Arthritis |  |  | |  |  |  |
| Asthma |  |  | |  |  |  |
| Coronary Artery/Heart Disease |  |  | |  |  |  |
| Cancer |  |  | |  |  |  |
| Cataract |  |  | |  |  |  |
| Depression |  |  | |  |  |  |
| Diabetes Mellitus |  |  | |  |  |  |
| Eczema |  |  | |  |  |  |
| Epilepsy |  |  | |  |  |  |
| Gastrointestinal disorder |  |  | |  |  |  |
| Glaucoma |  |  | |  |  |  |
| Ischemic Heart Disease/Heart Attack |  |  | |  |  |  |
| High Blood Pressure |  |  | |  |  |  |
| High Cholesterol |  |  | |  |  |  |
| Macular Degeneration |  |  | |  |  |  |
| Mental Illness |  |  | |  |  |  |
| Migraine Headaches |  |  | |  |  |  |
| Osteoporosis |  |  | |  |  |  |
| Renal/Kidney Disease |  |  | |  |  |  |
| Stroke |  |  | |  |  |  |
| Thyroid Disease |  |  | |  |  |  |
| Other: |  |  | |  |  |  |

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| **HEALTH MAINTENANCE** | | |
| **Have you had these vaccines?** | **Yes (Date)** | **No** |
| Flu |  |  |
| Pneumonia |  |  |
| Tetanus |  |  |
| Shingles |  |  |
| Coronavirus – Type? |  |  |
| **Have you had these tests?** | **Yes, date (month/year)** | **No** |
| Bone Density Screening |  |  |
| Colorectal Cancer Screening |  |  |
| Dental Exam |  |  |
| Diabetic Eye Exam |  |  |
| Eye Exam |  |  |
| Mammogram |  |  |
| Pap Smear |  |  |

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| **MEDICATIONS** | | | |
| * I am not taking any medications. | | | |
| * I brought a list of my medications from home. [You do not need to write them in the list] | | | |
| List all medications including over the counter, alternative, herbal, and prescriptions. | | | |
| **Medication Name** | **Strength** | **Number of doses at one time?** | **How many times a day?** |
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Local Pharmacy: Phone Number:

Mail Order Pharmacy: Phone Number:

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| **ALLERGIES** | |
| Medication/Food/Environmental | Reaction |
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| **SOCIAL HISTORY** |

Occupation:

Current Home Status: □ Lives Alone □Lives w/ Spouse □Lives w/ Relatives □Domestic Violence

Do you have a living will? □Yes □ No

Do you have an advanced directive? □Yes □ No

Religion?:

Marital Status: □ Single □Married □Separated □Divorced □Widowed

Tobacco: □ Current every day □Current some day □Former, quit date? □Never

Type (if applicable):

Alcohol: □ Never □Rarely □Moderate □Daily □Drinks per week Type?

Caffeine: □ Never □Rarely □Moderate □Daily Type?

Use of illicit drugs: □ Never □Rarely □Former, quit date? Type?

Do you exercise? □Yes, Type? □ No

Are you sexually active? □Yes □ No

Smoke detector in the house? □Yes □ No

Do you have any pets? □Yes, Type? □ No

Do you travel outside of the USA? □Yes, Where? □ No

Occupational Exposures: □ Noise □Dust □Chemical Solvents □Airborne particles

**Thank you for giving us the opportunity to care for you today!**