Physicians Primary Care of Southwest Florida

Patient History-Family Practice/Internal Medicine

Patient Name: _____ Patient DOB: _____

Medical Problems - Please list or check **current** medical problems:

____Diabetes ____Emphysema ____**Hyper**thyroid ____**Hypo**thyroid ____Atrial Fibrillation ____Hypertension

____High Cholesterol ____GERD ____Arthritis

Other:

_____

_____

Please list **past** medical problems:

_____

_____

_____

Hospitalizations/Surgeries - List all Hospitalizations/ Surgeries (including dates if known)

_____Cholecystectomy (Gallbladder) _____Appendectomy (Appendix) _____Rotator Cuff Repair (Right or Left)

_____Hernia Repair _____Pacemaker Insertion _____Coronary Artery Bypass Graft (CABG) _____C-Section

_____Knee Replacement (Right or Left) _____Tonsillectomy _____Back Surgery

_____Hysterectomy (Total or Partial) _____Neck Surgery _____Hip Replacement (Right or Left)

Other:

_____

_____

Allergies - List Allergies and Reactions

_____

_____

Family History

	Age	Alive or Deceased	All Health Problems/ Cause of Death
Father:			
Mother:			
Brother's:			
Sister's:			
Son's:			
Daughter's:			
Maternal Grandparents:			
Paternal Grandparents:			

Physicians Primary Care of Southwest Florida

Patient History-Family Practice/Internal Medicine

Patient Name: _____ **Patient DOB:** _____

Social History	**Women Only**
Lived in SW FL how long? Originally From?	Age when periods began?
Are you a permanent or seasonal resident?	Number of pregnancies?
Most recent primary occupation?	Number of live births?
Marital status: S M D W Separated	Number of miscarriages?
Language spoken at home?	Have you had hysterectomy? Yes or No
Last grade completed?	Do you have your ovaries? Yes or No
Do you have a religious preference?	Do you have your cervix? Yes or No
What are your hobbies or Interests?	Date of last pap smear?
Are you right or left handed? Ambidextrous?	Date of last mammogram?
Do you exercise regularly?	Are you still having periods?
Do you drink caffeinated beverages?	Are your periods regular?
If yes, what is your usual drink and how many per day?	What are you using for contraception?
Do you drink alcohol? If yes, how often and what kind?	Do you perform self breast exams?
Have you used recreational drugs?	Have you reached menopause? Yes or No
Do you smoke? If yes, how many packs per day?	If yes, at what age?
How long have you been smoking?	
If you smoked in the past, when did you quit?	**Preferred Local Pharmacy:**
Do you use a cane, walker, or wheelchair?	
Is it OK to leave test results on your answering machine?	**Preferred Mail Order Pharmacy**:
If yes, do you prefer your cell or home number?	

General Information	**Vaccinations/Immunizations**
Result of last TB (PPD) test:	Date of last Pneumococcal Vaccine:
Date of last TB (PPD) test:	Date of last Influenza (flu) Vaccine:
For Male Patients: Date of last PSA:	Date of last Tetanus Shot:
Date of last Colonoscopy:	Date of last Gardasil (HPV) Injection:
Date of last DEXA/ bone density scan:	Date of last Zostavax (shingles):

Medications- List any medications that you are now taking. (including non-prescription medications)

Medication Name	**Dosage**	**Times Daily**