



**LONGWOOD
FAMILY
MEDICINE**

225 West State Road 434, Suite 211
Longwood, FL 32750-4890
407-786-0004 Fax 407-786-0016

PATIENT NAME _____ **DATE** _____

If person completing form is not the patient
what is relationship to patient _____

Occupation _____ Date of Birth _____

Race _____ Sex _____ Marital Status: M S D W

CURRENT MEDICAL CONDITONS

DRUG ALLERGIES

CURRENT MEDICATIONS

<i>DRUG NAME</i>	<i>DOSE</i>	<i>FREQUENCY</i>	<i>START DATE</i>

SCREENING TESTS

TEST	LAST DATE	UNKNOWN	NEVER
BREAST EXAM	_____	<input type="checkbox"/>	<input type="checkbox"/>
MAMMOGRAM	_____	<input type="checkbox"/>	<input type="checkbox"/>
PAP	_____	<input type="checkbox"/>	<input type="checkbox"/>
PSA	_____	<input type="checkbox"/>	<input type="checkbox"/>
CHOLESTEROL	_____	<input type="checkbox"/>	<input type="checkbox"/>
COLONOSCOPY	_____	<input type="checkbox"/>	<input type="checkbox"/>
TUBERCULOSIS	_____	<input type="checkbox"/>	<input type="checkbox"/>
RECTAL / STOOL	_____	<input type="checkbox"/>	<input type="checkbox"/>

VACCINES

VACCINE	LAST DATE	UNKNOWN	NEVER
PNEUMONIA	_____	<input type="checkbox"/>	<input type="checkbox"/>
MUMPS	_____	<input type="checkbox"/>	<input type="checkbox"/>
MEASLES	_____	<input type="checkbox"/>	<input type="checkbox"/>
RUBELLA	_____	<input type="checkbox"/>	<input type="checkbox"/>
POLIO	_____	<input type="checkbox"/>	<input type="checkbox"/>
TETANUS	_____	<input type="checkbox"/>	<input type="checkbox"/>
MENINGITIS	_____	<input type="checkbox"/>	<input type="checkbox"/>
HEPATITIS	_____	<input type="checkbox"/>	<input type="checkbox"/>
INFLUENZA	_____	<input type="checkbox"/>	<input type="checkbox"/>

MEDICAL HISTORY

CONDITION	CURRENT	PAST	CONDITION	CURRENT	PAST
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Prostate disease	<input type="checkbox"/>	<input type="checkbox"/>
Heart palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer / Other G.I. disorder	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Sexual dysfunction	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	Venereal disease	<input type="checkbox"/>	<input type="checkbox"/>
Peripheral vascular disease	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Allergies / Hay fever	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	Last Menstrual Period _____		

HOSPITALIZATIONS OR SURGERY

REASON OR PROCEDURE	DATE	REASON OR PROCEDURE	DATE



Patient Name _____ Date _____

FAMILY HISTORY

RELATIONSHIP	IF LIVING		IF DECEASED		Convulsions	High Blood Pressure	Bleeding Disorder	Thyroid Disease	Kidney Disease	Mental Illness	Heart Disease	Sickle Cell	Diabetes	Cancer	Stroke
	Age	State of Health	Age at death	Cause											
Father															
Mother															
Brothers / Sisters	-----	-----	-----	-----	---	---	---	---	---	---	---	---	---	---	---
(circle sex) M F															
M F															
M F															
M F															
M F															
Husband / Wife															
Sons / Daughters	-----	-----	-----	-----	---	---	---	---	---	---	---	---	---	---	---
(circle sex) M F															
M F															
M F															
M F															

HABITS / RISK FACTORS

- YES NO
- Do you smoke cigarettes? Packs daily _____ How long _____
 - Are you interested in stopping?
 - Have you smoked previously? Packs daily _____ How long _____
 - Do you use other tobacco products? Type _____
 - Do you drink alcohol? Amount _____ Frequency _____ Type _____
 - Do you drink coffee? Amount daily _____
 - Do you exercise? Type _____ Amount _____ Frequency _____
 - Do you eat a healthy diet?
 - Have you been exposed to asbestos?
 - Have you been exposed to tuberculosis?
 - Do you use any illicit drugs (marijuana, cocaine, etc.)?
 - Have you had a sexually transmitted disease?
 - Have you had sex with anyone you think might have HIV?
 - Are you a male who has sex with other males?
 - Have you shared needles or syringes to inject drugs?
 - Do you have contact with blood or other body fluids at work?

MEDICAL CARE

Last primary care physician: _____

Other current or recent physicians: _____
