BLOCK, NATION, CHASE & SMOLEN FAMILY MEDICINE

MEDICAL HISTORY

Please fill out completely and accurately. This becomes part of your permanent record and will help us to make recommendations regarding your care.

PATIENT NAME: _____ DATE OF BIRTH:_____

PAST MEDICAL HISTORY:

Have you a history of:	Check if yes
ALLERGIES / HAY FEVER	❑
ANEMIA	❑
ARTHRITIS	❑
ASTHMA / EMPHYSEMA / COPD	❑
BLOOD CLOT	❑
CANCER	❑
CHEST PAINS / ANGINA	❑
CHOLESTEROL PROBLEMS	❑
DEPRESSION OR ANXIETY	❑
DIABETES	❑
HEADACHES / MIGRAINES	❑
HIGH BLOOD PRESSURE	❑
HIV / AIDS	❑
INTESTINAL DISORDERS	❑
MITRAL VALVE PROLAPSE OR RHEUMATIC FEVER	❑
OTHER HEART PROBLEMS	❑
SEIZURES	❑
SLEEP DISORDERS	❑
STROKE / TIA	❑
THYROID PROBLEMS	❑
ULCERS	❑

DRUG USE : _____

TOBACCO USE: _____
(PACKS PER DAY & # OF YEARS)

ALCOHOL USE: _____
(AVERAGE AMOUNT OR FREQUENCY)

EXERCISE: _____ HOBBIES: _____

EDUCATION COMPLETED: _____

# of Pregnancies: _____ # of Deliveries: _____ # of Miscarriages:_____

Frequency of Periods: _____Last Menstrual Period_____Last PAP _____

Any Foreign Travel_____

FAMILY HISTORY:

	√	Which family member? Maternal or Paternal
DIABETES		
HIGH BLOOD PRESSURE		
HEART ATTACK		
HIGH CHOLESTEROL		
STROKE		
ASTHMA		
SUICIDE/DEPRESSION		
ALCOHOLISM		
CANCER (& WHAT TYPES)		
OTHER		

Current Medications & doses:_____

_____

_____

Allergies to Medicine and your reaction: _____

_____

Spouse/Children/Parents' Names & Ages:_____

_____

Previous Illness/Injuries/Hospitalizations/Surgeries including year:_____

_____

_____

_____

Last Tetanus Booster:_____ **Occupation & Employer:**_____

The above information is true and complete to the best of my knowledge.

Signature_____ **Today's Date:**_____

12/2015

2441 West State Rd 426 ● Suite 2011● Oviedo, Florida 32765 ● (407) 678-6888 ● Fax (407) 359-5454