# ALAFAYA WOODS FAMILY MEDICAL CENTER, P.A.

# PATIENT HISTORY FORM

Patient's name: ________________________________ Today's date: ________________________

Social security number: _________________________ Date of birth: _________________________

## Past Medical History

Previous physician's name: ______________________________ Date of last Exam: ______________________

Have you ever been hospitalized? ☐ Yes ☐ No If yes, what for?_______________________

Have you ever been tested for hepatitis A, B or C ☐ Yes ☐ No Which hepatitis virus? __________________

Have you been vaccinated for hepatitis B? ☐ Yes ☐ No If yes, date vaccine series complete _______

Have you been vaccinated for hepatitis A? ☐ Yes ☐ No If yes, date vaccine series complete _______

Have you had a sexually transmitted disease? ☐ Yes ☐ No Diagnosis _____________________________

## Which of the following conditions are you currently being treated or have been treated for in the past? (Please check)

☐ Heart disease / Murmur / Angina

☐ High Cholesterol

☐ High Blood Pressure

☐ Low Blood Pressure

☐ Heartburn (reflux)

☐ Anemia or Blood Problems

☐ Swollen Ankles

☐ Shortness of Breathe

☐ Asthma

☐ Lung Problems / Cough

☐ Sinus Problems

☐ Seasonal Allergies

☐ Tonsillitis

☐ Ear Problems

☐ Eye Disorder / Glaucoma

☐ Seizures

☐ Stroke

☐ Headaches / Migraines

☐ Neurological Problems

☐ Depression / Anxiety

☐ Psychiatric Care

☐ Diabetes

☐ Kidney / Bladder Problems

☐ Liver Problems / Hepatitis

☐ Arthritis

☐ Cancer

☐ Ulcers / Colitis

☐ Thyroid Problems

## Please describe any current or past medical treatment not listed above.

______________________________________________________________________________

______________________________________________________________________________

**Please list your past surgeries**

___________________________________________________________________________________________

___________________________________________________________________________________________

**Allergies**

Are you allergic to penicillin or any other drugs? ☐ Yes ☐ No

Please list: ______________________________________________________________________________

Medications
Please list: ______________________________________________________________________________

___________________________________________________________________________________________

**Social and Preventative History**

Do you currently smoke or chew tobacco? ☐ Yes ☐ No If no, have you in the past? ☐ Yes ☐ No
How many packs per day? _________________________

Do you currently drink alcohol, beer, or wine? ☐ Yes ☐ No If no have you in the past? ☐ Yes ☐ No
How many drinks per week? ______________

Do you currently drink coffee and/or tea? ☐ Yes ☐ No If yes, how many cups per day? ______________

Do you exercise daily/weekly? ☐ Yes ☐ No

Do you use seatbelts while driving? ☐ Yes ☐ No Do you wear a helmet while biking? ☐ Yes ☐ No

**Family History**

| | Living | Age (or age at death) | List serious illnesses |
|---|---|---|---|
| Mother | ☐ Yes ☐ No | ____________________ | ____________________________________ |
| Father | ☐ Yes ☐ No | ____________________ | ____________________________________ |
| Sisters | ☐ Yes ☐ No | ____________________ | ____________________________________ |
| | ☐ Yes ☐ No | ____________________ | ____________________________________ |
| | ☐ Yes ☐ No | ____________________ | ____________________________________ |
| Brothers | ☐ Yes ☐ No | ____________________ | ____________________________________ |
| | ☐ Yes ☐ No | ____________________ | ____________________________________ |
| | ☐ Yes ☐ No | ____________________ | ____________________________________ |

Has any member of your family (including children and parents) had any of the following diseases?

| Illness | Which family member? |
|---|---|
| Anemia or Blood Disease | ______________________________ |
| Cancer | ______________________________ |
| Diabetes | ______________________________ |
| Glaucoma | ______________________________ |
| Heart Disease | ______________________________ |
| High Blood Pressure | ______________________________ |
| HIV Disease / AIDS | ______________________________ |
| Mental Illness / Depression | ______________________________ |
| Stroke | ______________________________ |
| Other Serious Illness | ______________________________ |

## Females: Gynecological History

How many times have you been pregnant? __________ Date of last Pap Smear? ____________________________

Have you had an abnormal Pap Smear? ☐ Yes ☐ No Diagnosis: _________________ Follow up: _____________

Date of last mammogram: _______________________ Mammogram results: ______________________________

Have you had a sexually transmitted disease? ☐ Yes ☐ No Diagnosis __________________________________

Have you ever had a breast biopsy? ☐ Yes ☐ No Biopsy results: ____________________________________

By signing below, I hereby certify that to the best of my knowledge all the information I have furnished on this form is complete, true and accurate.

Patient/Legal Guardian Signature ______________________________________________ Date: __________________