Florida Primary Care & Sports Medicine
140 Pinnacles Drive
Palm Coast, FL 32164
(386) 313-6035

Medical History Form

Today's date: _____

Name: _____ **Gender:** Male ( ) Female ( )

Date of Birth: _____ **Race:** ( ) White ( ) Black ( ) Asian ( ) Hispanic ( ) North American Native ( ) Other

Pharmacy: _____

Medical Problems:

Please check all that apply to you:

Chronic headaches/migraines	[ ]	Type 1 Diabetes	[ ]
Epilepsy/ Seizures	[ ]	Type 2 Diabetes	[ ]
Asthma	[ ]	High blood pressure	[ ]
COPD	[ ]	Thyroid Disease	[ ]
Heart Disease	[ ]	Glaucoma	[ ]
Anemia	[ ]	Hernia	[ ]
High Cholesterol	[ ]	Stroke	[ ]
Tuberculosis	[ ]	Cerebral Palsy	[ ]
Ulcer(s)	[ ]	Autoimmune Disease	[ ]
Hepatic Disorder	[ ]	Parkinson's Disease	[ ]
Kidney Disease	[ ]	Neuropathy	[ ]
Cancer	[ ]	AIDS/HIV	[ ]
Eczema	[ ]	Lyme Disease	[ ]
Back Pain	[ ]	Rheumatoid Arthritis	[ ]
Arthritis	[ ]	Blood/Plasma Transfusion	[ ]
Fibromyalgia	[ ]	Multiple Sclerosis	[ ]
Anxiety	[ ]	Anorexia/Bulimia	[ ]
Insomnia	[ ]	Memory Loss	[ ]
Depression	[ ]	Constipation	[ ]
ADD/ADHD	[ ]	Irritable Bowel Syndrome	[ ]
Incontinence	[ ]	Hearing Loss	[ ]
Osteopenia	[ ]	Pancreatitis	[ ]
Osteoporosis	[ ]	Esophageal Reflux	[ ]
Allergies	[ ]	Lupus	[ ]
Atrial Fibrillation	[ ]	Bipolar Disorder	[ ]
STD	[ ]	Palpitations	[ ]
Heart Attack	[ ]	Vertigo/Dizziness	[ ]
Neurological Disorder	[ ]	Crohn's Disease	[ ]
Congestive Heart Failure	[ ]	Blindness	[ ]

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Surgical History:

SURGERY	DATE
1.	
2	
3.	
4.	
5.	

Have you had a colonoscopy within the past 10 years? _____ If yes, what date or year: _____
Date of last DEXA/Bone Density (if applicable): _____
Date of last Mammogram (if applicable): _____

Additional Medical/Surgical History & Details:

_____
_____
_____

List all Physicians you see. (Example: Dr. Marini - Cardiologist)

1.
2.
3.

Family History: *Please list any known medical problems for relatives listed below:*
EX: Diabetes, Cancer, Heart Attack, Depression, High blood pressure.
Mother:_____
Father: _____
Brother(s):_____
Sister(s): _____
Other: _____
_____
[ ] Adopted- Family history unknown

Habits:
What do you do for exercise? _____
How often? _____
Tobacco (chew/smoke) _____ **per** (day) (week)
Alcohol (beer/wine/etc.) _____ **per** (day) (week) (month) (year)
Street Drugs: (marijuana, etc.): _____ how often? _____
Caffeine: (coffee/tea/soda): _____ per (day) (week) (month)
Any trouble sleeping [ ] YES [ ] NO

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Over the last 2 weeks, how often have you been bothered by the following problems?

1. Little interest or pleasure in doing things

( ) Not at all ( ) Several days ( ) More than half the days ( ) nearly every day

2. Feeling down, depressed or hopeless

( ) Not at all ( ) Several days ( ) More than half the days ( ) nearly every day

Allergies:

What allergies do you have? What reaction occurs? (EX: Penicillin-shortness of breath, Latex-rash)

ALLERGIES	REACTION
1.	
2.	
3.	
4.	
5.	
6.	
7.	

Medications:

Please include all Prescriptions, OTC meds, vitamins and supplements.

MEDICATION NAME	DOSAGE	HOW OFTEN
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13		
14.		
15.		