Sample Medical Center
5596 W Sample Rd Margate, FL 33073
Office 954-968-4000 Fax 954-968-4099

Name: ______________________ **DOB:** __________ **Date:** ______________

Information provided on this form will assist your health care provider to better understand your medical conditions and concerns. All questions are optional and will be kept confidential.

Emergency contact Name : ______________________ **Phone number:** ____________

Main reason for today's visit:

____

Other Concerns:

____

Email Address: ______________________________

ALLERGIES NO KNOWN ALLERGIES ·

List anything that you are allergic to (medications, food, bee stings, etc.) and how each affects you.
ALLERGY REACTION

1.______________ 2.______________ 3.______________

Please list all the medications you are taking. Include prescribed drugs and over-the-counter drugs, such as vitamins and inhalers.

DRUG NAME STRENGTH FREQUENCY TAKEN

1.______________ 2.______________
3.______________ 4.______________
5.______________ 6.______________
7.______________ 8.______________
9.______________ 10.______________

Immunizations and most recent date

- Flu Shot Date: ________ · Shingles Date: ________
- Tetanus/Diphtheria/Pertussis (DPT) Date: ________ · Pneumonia Vaccine Date: ________
- Chickenpox Date: ________ · Hepatitis A Date: ________
- Measles/Mumps/Rubella (MMR) Date: ________ · Hepatitis B Date: ________
- Human Papillomavirus (HPV) Date: ________ · Hemophilus Influenza Type B (Hib) Date: ________
- Meningitis Vaccine Date: ________ · Td or Tdap Date: ________

(WOMEN ONLY) OBSTETRIC AND GYNECOLOGICAL HISTORY

Age at First Menstrual Cycle ________ Date of Last Menstrual Cycle Date: ________

Age at First Child Birth ________ Date of Last Pap Smear Date: ________ · normal · abnormal

Current Birth Control ________

Date of Last Mammogram Date: ________ Location: ______________ · normal · abnormal

If Post-Menopausal, Age at Menopause ______ Post-Menopausal bleeding · yes · no

Hysterectomy · Yes · No Tubal Ligation · Yes · No Cesarean Section · Yes · No

Breast Augmentation · Yes · No Breast Reduction · Yes · No Mastectomy · Yes · No

MEN AND WOMEN

Date of Last Colonoscopy Date: ________ Location: ______________________________ ☐ normal ☐ abnormal

PAST MEDICAL HISTORY

Please check all that apply:

- ☐ Abnormal Vaginal Bleeding
- ☐ Acid Reflux (GERD)
- ☐ Anemia
- ☐ Asthma
- ☐ Back Pain
- ☐ Bladder or Kidney Problems
- ☐ Cancer
- ☐ Congestive Heart Failure (CHF)
- ☐ COPD
- ☐ Difficulty Sleeping
- ☐ Dizziness
- ☐ Dementia/Alzheimers
- ☐ Depression/Anxiety
- ☐ Diabetes
- ☐ DVT/Blood Clot
- ☐ Epilepsy/Seizures
- ☐ Headaches/Migraines
- ☐ Heart Problems
- ☐ High Blood Pressure (HTN)
- ☐ High Cholesterol
- ☐ Kidney Stones
- ☐ Parkinson's Disease
- ☐ Recurrent Urinary Tract Infection (UTI)
- ☐ Sleep Apnea
- ☐ Thyroid Disease
- ☐ TIA/Stroke
- ☐ Other: ____________________
- ☐ Other: ____________________

PATIENT HEALTH QUESTIONNAIRE-2 (PHQ2)

Over the past 2 weeks, how often have you been bothered by any of 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

PAST SURGICAL HISTORY

SURGERY	REASON	YEAR	HOSPITAL

SOCIAL HISTORY

Marital Status

- ☐ Married
- ☐ Separated
- ☐ Widowed
- ☐ Single
- ☐ Divorced
- ☐ Domestic Partner

Tobacco Use

If not currently, did you ever use tobacco? ☐ Yes ☐ No

- ☐ Cigarettes ____ pks/day
- ☐ Chew ____ per day
- ☐ Cigars ____ per day
- ☐ # of years ____ or year quit ________

Exercise Level

- ☐ None (No exercise)
- ☐ Occasional exercise
- ☐ Moderate exercise
- ☐ High level exercise

Alcohol Use

Do you drink alcohol? ☐ Yes ☐ No

If yes, how often?

Daily ☐ Yes ☐ No

Socially Only ☐ Yes ☐ No

Occasionally ☐ < 3 times a week ☐ > 3 times a week

FAMILY HEALTH HISTORY

RELATION	ALIVE?	AGE	SIGNIFICANT HEALTH PROBLEMS
Grandmother (maternal)	Y/N	___	☐ Alcohol abuse ☐ Alzheimer's Disease ☐ Arthritis ☐ Asthma ☐ Autism ☐ Cancer ☐ COPD ☐ Depression ☐ Diabetes ☐ Disorder of Thyroid Gland ☐ Heart Disease ☐ High Blood Pressure ☐ High Cholesterol ☐ Obesity ☐ Osteoporosis ☐ Stroke
Grandfather (maternal)	Y/N	___	☐ Alcohol abuse ☐ Alzheimer's Disease ☐ Arthritis ☐ Asthma ☐ Autism ☐ Cancer ☐ COPD ☐ Depression ☐ Diabetes ☐ Disorder of Thyroid Gland ☐ Heart Disease ☐ High Blood Pressure ☐ High Cholesterol ☐ Obesity ☐ Osteoporosis ☐ Stroke
Grandmother (paternal)	Y/N	___	☐ Alcohol abuse ☐ Alzheimer's Disease ☐ Arthritis ☐ Asthma ☐ Autism ☐ Cancer ☐ COPD ☐ Depression ☐ Diabetes ☐ Disorder of Thyroid Gland ☐ Heart Disease ☐ High Blood Pressure ☐ High Cholesterol ☐ Obesity ☐ Osteoporosis ☐ Stroke
Grandmother (paternal)	Y/N	___	☐ Alcohol abuse ☐ Alzheimer's Disease ☐ Arthritis ☐ Asthma ☐ Autism ☐ Cancer ☐ COPD ☐ Depression ☐ Diabetes ☐ Disorder of Thyroid Gland ☐ Heart Disease ☐ High Blood Pressure ☐ High Cholesterol ☐ Obesity ☐ Osteoporosis ☐ Stroke
Father	Y/N	___	☐ Alcohol abuse ☐ Alzheimer's Disease ☐ Arthritis ☐ Asthma ☐ Autism ☐ Cancer ☐ COPD ☐ Depression ☐ Diabetes ☐ Disorder of Thyroid Gland ☐ Heart Disease ☐ High Blood Pressure ☐ High Cholesterol ☐ Obesity ☐ Osteoporosis ☐ Stroke
Mother	Y/N	___	☐ Alcohol abuse ☐ Alzheimer's Disease ☐ Arthritis ☐ Asthma ☐ Autism ☐ Cancer ☐ COPD ☐ Depression ☐ Diabetes ☐ Disorder of Thyroid Gland ☐ Heart Disease ☐ High Blood Pressure ☐ High Cholesterol ☐ Obesity ☐ Osteoporosis ☐ Stroke
Brother/Sister	Y/N	___	☐ Alcohol abuse ☐ Alzheimer's Disease ☐ Arthritis ☐ Asthma ☐ Autism ☐ Cancer ☐ COPD ☐ Depression ☐ Diabetes ☐ Disorder of Thyroid Gland ☐ Heart Disease ☐ High Blood Pressure ☐ High Cholesterol ☐ Obesity ☐ Osteoporosis ☐ Stroke
Brother/Sister	Y/N	___	☐ Alcohol abuse ☐ Alzheimer's Disease ☐ Arthritis ☐ Asthma ☐ Autism ☐ Cancer ☐ COPD ☐ Depression ☐ Diabetes ☐ Disorder of Thyroid Gland ☐ Heart Disease ☐ High Blood Pressure ☐ High Cholesterol ☐ Obesity ☐ Osteoporosis ☐ Stroke

PREVIOUS PRIMARY CARE PROVIDER

Name of Provider: ______________________

Address: ______________________

____

____

Phone: ______________________

Fax: ______________________

Insurance: ______________________

Member ID: ______________________

PHARMACY

Pharmacy Name: ______________________

Address: ______________________

____

____

Phone: ______________________

Fax: ______________________

____
Parent, Guardian, or Caregiver Signature

____
Date

____
Patient Signature

____
Date