Orlando Health Family Medicine
587 E. State Rd. 434 Suite 1071
Longwood, FL 32750 407.767.8500

Welcome!

Patient History Form

Today's date:___/___/___

Patient Info

Legal Name _____ Age _____ Birthdate: ___/ ___/ ___
Last First Middle
Occupation: _____ Race: _____
Sex: O Male O Female Marital Status: O Single O Married O Widowed O Divorced/Separated
Spouse/Partner's name _____ Children's names/ ages _____

Family History

Has any blood relative had any of the following? Please indicate which relative(s).

O Allergies _____ O Depression _____ O HIV/AIDS _____ O Migraine _____
O Anemia _____ O Diabetes _____ O Heart Disease _____ O Obesity _____
O Arthritis _____ O Drug/Alcoholism _____ O High Blood Press. _____ O Osteoporosis _____
O Asthma _____ O Epilepsy _____ O High Cholesterol _____ O Stroke _____
O Bleeds easily _____ O Glaucoma _____ O Kidney Disease _____ O Thyroid Disease _____
O Cancer _____ O Gout _____ O Mental illness _____ O Tuberculosis _____
O Other _____

Father's age ____ Health: O Good O Fair O Poor O Deceased (age) ____ Siblings' Health: _____
Mother's age ____ Health: O Good O Fair O Poor O Deceased (age) ____ Children's Health: _____

Tobacco Use: O Never smoked O Currently smoke ____ packs per day since age ____ Ever quit ? _____
O chewing tobacco O dip snuff Quit smoking ___/ ___/ ___ after ___ packs/day for ___ yrs
Any smokers in home? O Yes O No **Any other drug use?** (list) _____

Alcohol Use: O Never drink O I average ___ beers; ___ glasses wine; ___ oz. liquor per O week O month O yr.
O Stopped drinking ___/ ___/ ___ after ___ yrs. Any alcoholics in home? O Yes O No

Caffeine Use: ___ cups of coffee/day (approx. size of cup: ___ oz.) ___ cups/glasses tea/day ___ sodas/day

Safety Issues: Do you have working smoke detectors in your home? ____ % of time seatbelts used in car ____
Is there anyone in your home who physically hurts/threatens you, or makes you feel afraid? ____

Have you recently had any of the following symptoms/diseases ?

O Change in appetite
O Dizziness/ fainting spells
O Night sweats/ hot flashes
O Persistent fever
O Recent weight changes
O Sensitivity to heat or cold
O Sleeplessness
O Tire easily or weakness
O Double or blurred vision
O Eye pain
O Eye infections- frequent
O Failing vision
O Wear glasses or contacts?
O Last eye exam ___/ ___/ ___
O Decrease in hearing
O Discharge from ears
O Ear pain
O Ringing in ears
O Frequent nosebleeds
O Loss of smell
O Sinus trouble
O Dental problems
O Last Dental visit ___/ ___/ ___
O Persistent hoarseness
O Sore throat
O Sore tongue or gums

O Artificial heart valves
O Chest pain or discomfort
O High blood pressure
O Heart murmur
O Irregular pulse
O Mitral valve prolapse
O Pacemaker
O Palpitations or fluttering heart
O Varicose veins
O Asthma/wheezing
O Bronchitis-chronic
O Chronic or frequent cough
O Emphysema
O Pneumonia/pleurisy
O Short of breath with exertion
O Short of breath lying flat
O Coughing blood or phlegm
O Last chest X-ray ___/ ___/ ___
O Abdominal pain-chronic
O Bloody or black tarry stools
O Constipation O Diarrhea
O Difficulty swallowing
O Diverticulosis
O Heartburn/indigestion
O Hemorrhoids
O Hepatitis/yellow jaundice

O Nausea/Vomiting-persistent
O Ulcers
O Vomiting up blood
O Blood in urine
O Difficulty starting urine
O Frequent urination (day)
O Frequent urination (night)
O Kidney stones
O Leakage of urine
O Painful urination
O Urine infections-frequent
O Venereal disease
O Lack of sex drive
O Discharge from penis
O Impotence
O Pain or lump on testicles
O Last period began___/___/___
O Last Pap/ pelvic ___/___/___
O Last mammogram___/___/___
O Age periods began _____
O Number of pregnancies ____
O Number of live births ____
O Number of miscarriages ____
O Number of abortions ____
O Type of birth control _____
O BC pill name _____

O Abnormal Pap in past
Flow: O Heavy O Mod
O Light O Regular O Irreg
O Pain/cramps with flow
____ days of flow
____ length of cycle
O Pain with intercourse
O Arthritis O Gout
O Backaches-recurrent
O Joint pain/stiffness
O Leg cramps w/ walking
O Leg cramps at night
O Muscle weakness
O Swelling of joints
O Changes in nails/hair
O Easy bleeding/bruising
O Eczema O Psoriasis
O Moles changing/irritated
O Skin rash
O Breast lump/discharge
O Headaches
O Migraines
O Paralysis O Seizures
O Tremor/Hands shaking
O Poor coordination
O Numbness/Tingling
O Mental illness
O Moodiness - excessive Nervousness

O During the past month have you been bothered by feeling down, depressed
O During the past month have you been bothered by little interest or pleasure in doing things?
O Depression
O Memory loss
O Phobias
O Tearfulness
O Chronic fatigue
O Diabetes
O Increase in thirst
O Thyroid disease
O Anemia
O Blood transfusions
O Cancer
O Swollen lymph nodes
O Hayfever/Allergies
O Hives
O HIV/AIDS O Syphilis
O Chicken pox
O Measles O Mumps
O Rubella O Polio
O Rheumatic fever
O Tuberculosis (TB)

Please list any other concerns or comment on any of the above:

Signature

I affirm that the information I have given is correct and complete to the best of my knowledge. I understand it is my responsibility to inform this office of any change in my medical status.

Signature:_____ Date: ___/ ___/ ___

Reviewed by Physician_____ Date: ____/____/____

List all prescription and over the counter medications you are currently taking:

Revisions (To be completed by physician)