ORLANDO HEALTH Physicians
Summerport Family Medicine Group

Summerport Family Medicine
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Adult Medical History

Name: _____ Date of Birth: ____/_____/_____ Age: _____
Ethnicity: Hispanic/Latino _____ Not Hispanic/Latino _____ Not reported _____ Other _____
Race: American Indian ___ Asian ___ Black ___ Caucasian ___ Native Hawaiian ___ Other/Unknown ___ Declined to provide ____

Last time you had a complete physical? (Including EKG, X-ray, Lab work) _____
List any other physicians who provided you with routine medical care? _____

Past Medical History: Please circle if you now have (or in the past had) any of the following:

AIDS/HIV Positive	Bypass Surgery	Emphysema	Hepatitis/Liver Disease	Prostate Trouble
Allergies/Hay fever	Cancer	Epilepsy	High Blood Pressure	Recurring Bronchitis
Anemia	Circulatory Problems	Fainting Spells	High Cholesterol	Recurring Ear Infection
Angina	Chronic Fatigue	Gallbladder Disease/Surgery	Kidney Infections	Rheumatic Fever
Anxiety	Colon/Bowel Trouble	Glaucoma/Cataracts	Kidney Stones	Sinus Trouble
Arthritis	Depression	Gout	Migraine/Headaches	Stomach/Duodenal Ulcers
Asthma	Diabetes Mellitus	Hearing Trouble	Mitral Valve Prolapse	Stroke
Bladder Infections	Drug/Alcohol Problems	Heart Murmur	Neck/Back Problems	Suicide Attempt
Bleeding Disorder	Easy Bruising	Heart Trouble	Palpitations	Thyroid Problems
Broken Bones	Eczema/Skin Cancer	Hemorrhoids/Piles	Pulmonary Emboli	Triglycerides

Previous Surgery (ies) (include date(s): _____

FEMALES ONLY:
Pregnancies _____ Children _____ Miscarriages _____ Abortion _____
Last Pap smear ____/_____/_____ Last mammogram ____/_____/_____

Please circle if you now have (or in the past had) any of the following:

Abnormal Paps	Endometriosis	Hysterectomy	PID/Pelvic Infections
Breast Surgery	Fibrocystic Breast Disease	Menstrual Difficulties	PMS
D&C	Gonorrhea/Syphilis/Chlamydia	Ovarian Cysts	Tubal Ligation

ALLERGIES: Circle any of the following allergies you have

Penicillin Erythromycin Sulfa Tetracycline Codeine Aspirin
Ibuprofen (NSAIDS) Other _____

MEDICATIONS: List ALL the medications you are currently taking or have taken in the past month.

_____
_____

SOCIAL HISTORY:
Do you smoke? YES NO How much? _____ If you quit, when? _____
Do you drink alcohol/beer? YES NO How much? _____ If you quit, when? _____
Do you drink coffee/tea? YES NO How much? _____ If you quit, when? _____
Do you or have you ever abused prescription drugs or used street drugs? YES NO
Over the past 2 weeks, have you felt down, depressed or hopeless? YES NO
Over the past 2 weeks, have you had less pleasure in doing things you normally like to do? YES NO
Does anyone ever hurt you, harm you, or make you do things you don't want to do? YES NO

DIET: Regular ____ Low fat/Low Cholesterol ____ Vegetarian ____ Diabetic ____ Low Salt ____ Weight Reduction ____ Other Type ____
EXERCISE: Regularly ____ Occasionally ____ Not at all ____

FAMILY HISTORY: Circle if the following health problems occur or have occurred in your family:

Alcoholism	Bleeding Disorders	Emphysema	High Blood Pressure	Seizures
Allergies	Cancer	Epilepsy	High Cholesterol	Suicide
Anemia	Depression	Heart Attacks	Leukemia	Strokes
Asthma	Diabetes	Heart Trouble	Ulcer Disease	Other:

	AGE	LIST ANY HEALTH PROBLEMS	Deceased Age or N/A	CAUSE OF DEATH
Father				
Mother				
Brother(s)				
Sisters(s)				