ORLANDO HEALTH **Florida Infectious Disease Group**

PATIENT NAME: _____ **DATE OF BIRTH:**_____

REASON FOR TODAY'S VISIT (Please describe):_____

_____

Is this a work related injury? ☐ Yes ☐ No Date of injury_____Date last worked_____Have you returned to work? ☐ Yes ☐ No

CURRENT SYMPTOMS (Please check the symptoms you currently have or have had in the past year):

ALLERGIES (Please check which applies): ❑ None ❑Sulfa ❑ Penicillin ❑ Codeine ❑ Other (please list):_____

GENERAL
❑ Chills
❑ Depression
❑ Dizziness/Fainting
❑ Fever
❑ Forgetfulness
❑ Headache
❑ Loss of sleep
❑ Nervousness
❑ Night Sweats
❑ Other:

GASTROINTESTINAL
❑ Bloating
❑ Constipation
❑ Diarrhea
❑ Other:

SKIN
❑ Hives
❑ Itching/Rash
❑ Shingles
❑ Sore that won't heal
❑ Other:

MUSCLE/JOINT/BONE
Pain, weakness and/or numbness in:
❑ Arms
❑ Back
❑ Hands/Feet
❑ Legs
❑ Neck
❑ Shoulders
❑ Other:

CARDIOVASCULAR
❑ Chest pain
❑ Irregular heartbeat
❑ Poor circulation
❑ Rapid heart beat
❑ Swelling of ankles
❑ Other:

EYE,EAR,NOSE,THROAT
❑ Blurred vision
❑ Difficulty swallowing
❑ Double vision
❑ Earache
❑ Hoarseness
❑ Loss of hearing
❑ Nosebleeds
❑ Persistent cough
❑ Ringing in ears
❑ Other:

GENITO-URINARY
❑ Blood in urine
❑ Frequent urination
❑ Lack of bladder control
❑ Painful Urination
❑ Other:
❑ Other:

PAST MEDICAL HISTORY (Please check which applies):

❑ None
❑ AIDS
❑ Alcoholism
❑ Anemia
❑ Asthma
❑ Bleeding disorder
❑ Cancer (specify): _____
❑ Cataracts
❑ Coronary artery disease
❑ Diabetes
❑ Emphysema
❑ Glaucoma
❑ Goiter
❑ Gout
❑ Heart attack
❑ Heart disease
❑ Hepatitis: Type_____
❑ Herpes
❑ High blood pressure
❑ High cholesterol
❑ HIV positive
❑ Illegal drug use
❑ Kidney disease
❑ Liver disease
❑ Migraine headaches
❑ Mononucleosis
❑ Osteoarthritis
❑ Pneumonia
❑ Psychiatric care
❑ Rheumatic fever
❑ Rheumatoid arthritis
❑ Shingles
❑ Skin abscesses
❑ Stroke
❑ Suicide attempt
❑ Tuberculosis
❑ Typhoid fever
❑ Ulcers – feet
❑ Ulcers (specify):
❑ Other:

PAST SURGERY (Please check which applies):

❑ None
❑ Ankle surgery
❑ Appendectomy
❑ C-section
❑ Defibrillator
❑ Fracture repair
❑ Gallbladder
❑ Hip surgery
❑ Hysterectomy
❑ Incision and debridement of skin abscess
❑ Knee Surgery
❑ Knee/Hip replacement
❑ Pacemaker
❑ Shoulder surgery
❑ Tonsillectomy
❑ Tubal ligation
❑ Other:

SOCIAL HISTORY (Please check which applies):

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow
Work Status: ☐ Employed ☐ Not employed ☐ Disabled ☐Student ☐ Occupation: (specify)_____
Do you reside: ☐ At home ☐ Rehab center ☐ Assisted living ☐ Homeless
Caffeine use: ☐ Yes ☐ No Tobacco use: ☐ Yes (amount) :_____ ☐ No
Alcohol use: ☐ Never ☐ Social ☐ Daily use ☐ Heavy use ☐ Previous alcohol use

SEXUAL HISTORY: ☐ Same sex ☐ Opposite sex ☐ Both sexes Sexually active? ☐ Yes ☐ No

FAMILY HISTORY: (Please check all that apply):

	Mother	Father	Other (specify)
Asthma	❑	❑	❑ :_____
Breast Cancer	❑	❑	❑ :_____
Cancer (specify): _____	❑	❑	❑ :_____
Diabetes Mellitus	❑	❑	❑ :_____
Heart Disease	❑	❑	❑ :_____
Stroke	❑	❑	❑ :_____
Other:_____	❑	❑	❑ :_____

LIST CURRENT MEDICATION:

Name:	***Dosage:***