# CARINE FAMILY MEDICINE

**1811 SHORE DRIVE SOUTH - SOUTH PASADENA, FLORIDA 33707 - PHONE 727 391 4100 - FAX 727 398 2067**

## NEW PATIENT

## MEDICAL HISTORY FORM

| Please check a box | No | Yes | If yes, please specify: |
|---|---|---|---|
| Infection disease | | | |
| Neurologic Condition (MS/Parkinson's) | | | |
| Pediatric Development Condition | | | |
| Skin Disease | | | |
| Spinal Cord Injury | | | |
| Degenerative Joint Disease | | | |

| Please mark one box for each items | Yes | No | Family | Please mark one box for each items | Yes | No | Family |
|---|---|---|---|---|---|---|---|
| Smoking | | | | Sexual Dysfunction | | | |
| Diabetes | | | | Bladder/Bowel Problems | | | |
| Heart disease(s) | | | | Groin numbness | | | |
| High blood pressure | | | | Arthritis | | | |
| Chest Pain | | | | Osteoporosis | | | |
| Stroke | | | | Depression | | | |
| Kidney Condition | | | | Anxiety | | | |
| Blood Clot/DVT | | | | Psychological Disorders | | | |
| Any implants/Pacemakers | | | | Seizures | | | |
| Breathing problems/Asthma | | | | Dizziness/Faintness | | | |
| Difficulty Swallowing | | | | Ringing Ears | | | |
| Cancer: | | | | Allergies | | | |
| Circulation/Vascular problems | | | | Head Injuries | | | |
| Peripheral Neuropathy | | | | Obesity | | | |
| Abnormal Weight Loss | | | | Chronic pain | | | |
| Double Vision | | | | Fractures | | | |
| Night Sweat/pain | | | | Infections | | | |
| Are you pregnant? | | | | Fever | | | |

## SURGERY HISTORY

| **TYPE** (specify left / right) | **DATE** | **LOCATION/FACILITY** |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

## ALLERGIES

□ NO KNOW ALLERGIES

| Medication / Food / Substance | Reactions |
|---|---|
| | |
| | |
| | |
| | |

Patient/ Legal Representator Name:_____ Date: _____.

Signature:_____

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## VACCINATION HISTORY

□ NO CHANGE

| | |
|---|---|
| Last Tetanus Booster or Tdap:<br>/ / | Last Pneumovax (Pneumonia):<br>/ / |
| Last Flu Vaccine:<br>/ / | Last Prevnar:<br>/ / |
| Last Zoster Vaccine (Shingles):<br>/ / | Other vaccines<br>/ / |

## MEDICATIONS

□ NO MEDICATION (PRESCRIPTION OR OVER THE COUNTER)

| MEDICATIONS (Please list ALL) | DOSE (Mg., pill, ect.) | TIMES PER DAY |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

*If you need more room to list medications, please write them on a blank sheet of paper with the required information*

## HEALTH MAINTENANCE SCREENING TEST HISTORY

| | | | |
|---|---|---|---|
| CHOLESTEROL | Date: / / | Facility/Provider: | Abnormal Result? Y / N |
| COLONOSCOPY | Date: / / | Facility/Provider: | Abnormal Result? Y / N |
| MAMMOGRAM | Date: / / | Facility/Provider: | Abnormal Result? Y / N |
| PAP SMEAR | Date: / / | Facility/Provider: | Abnormal Result? Y / N |
| BONE DENSITY | Date: / / | Facility/Provider: | Abnormal Result? Y / N |

## FAMILY MEDICAL HISTORY

□ NO SIGNIFICANT FAMILY HISTORY IS KNOWN

| CHECK ALL THAT APPLY | YES (Relationship) | NO | CHECK ALL THAT APPLY | YES (Relationship) | NO |
|---|---|---|---|---|---|
| Alcohol Abuse | | | High Cholesterol | | |
| Asthma | | | High Blood Pressure | | |
| Emphysema (COPD) | | | Kidney Disease | | |
| Depression/Anxiety | | | Stroke | | |
| Bipolar/Suicidal | | | Thyroid Disease | | |
| Diabetes | | | Migraines | | |
| Early Death | | | Cancer: _____ | | |
| Heart Disease | | | | | |

Patient/ Legal Representator Name:_____ Date: _____.



Signature:_____