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: / /	Last Pneumovax (Pneumonia): / /
Last Flu Vaccine: / /	Last Prevnar: / /
Last Zoster Vaccine (Shingles): / /	Other vaccines / /

MEDICATIONS

□ NO MEDICATION (PRESCRIPTION OR OVER THE COUNTER)

MEDICATIONS (Please list ALL)	DOSE (Mg., pill, ect.)	TIMES PER DAY
PHARMACY NAME AND ADDRESS: ______________________		

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:__________________________