CARSON FAMILY CARE CENTER

1259 S. Pinellas Avenue
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(727)938-1908

Welcome to our practice! As a new patient, please fill out the following health history to the best of your ability.

Patient Name: _____ Date: _____ SS # _____ Birth Date:_____

CHIEF COMPLAINT:_____ Location: _____
Please be advised we will not prescribe any control substances on the first visit (Where is the pain/problem?)

Severity: _____ Timing: _____ Duration: _____
(Mild/Moderate/Severe/Unbearable) (Does it occur at a specific time?) (How long have you had this problem?)

Associated signs/symptoms: _____
(What other associated problems have you been having?)

Modifying factors: _____
(What makes the pain/problem worse or better? Have you had previous episodes?)

PAST MEDICAL HISTORY: Have you ever had the following: (circle condition or fill in where appropriate)

CARDIOVASCULAR:

Arrhythmia	Y N	Coronary Artery Disease	Y N	Hypertension	Y N
Heart Problem (type: _____)	Y N	Deep Vein Thrombosis	Y N	Valvular Disease (type: _____)	Y N
Congestive Heart Failure	Y N	Hyperlipidemia	Y N	Other:_____	

PULMONARY:

Asthma	Y N	Cystic Fibrosis	Y N	Sleep Apnea	Y N
Chronic Bronchitis	Y N	Pneumonia	Y N	TB exposure/infection	Y N
COPD	Y N	Pulmonary Embolism	Y N	Other: _____	

GASTROINTESTINAL:

Cholelithiasis	Y N	Hepatitis (type: _____)	Y N	Peptic Ulcer Disease	Y N
Cirrhosis	Y N	Irritable Bowel Syndrome	Y N	Ulcerative Colitis	Y N
GERD	Y N	Pancreatitis	Y N	Other: _____	

RENAL/GENITOURINARY:

Acute or Chronic Renal Failure	Y N	Renal stones	Y N	Recurrent UTIs	Y N
Infertility	Y N	Urinary Incontinence	Y N	Other: _____	

MUSCULOSKELETAL:

Chronic Pain	Y N	Gout	Y N	Rheumatoid Arthritis	Y N
Fibromyalgia	Y N	Osteoarthritis	Y N	Sjogren's Disease	Y N
Fractures (where: _____)	Y N	Osteoperosis	Y N	Other: _____	

ENDOCRINE:

Addison's/Cushings Disease	Y N	Type II Diabetes	Y N	Hypothyroidism	Y N
Type I Diabetes (insulin dependent)	Y N	Hyperthyroidism	Y N	Other: _____	

NEUROLOGICAL:

Alzheimer's Disease	Y N	Down Syndrome	Y N	Parkinson's Disease	Y N
ADD/ADHD	Y N	Headaches (migraine or tension)	Y N	Seizure Disorder (type:_____)	Y N
CVA/Stroke (date: _____)	Y N	Multiple Sclerosis	Y N	(Frequency: _____ Last:_____)	
Dementia	Y N	Other:_____			

HEMATOLOGIC:

Iron-deficiency Anemia	Y N	Pernicious Anemia	Y N	Other:_____	

ALLERGY/IMMUNOLOGY/DERMATOLOGY:

Allergies	Y N	Eczema/Psoriasis	Y N	Frequent sinusitis	Y N
Chicken Pox	Y N	Otitis Media/Ear Pain	Y N	Other: _____	

CANCER:
Type: _____ DX Date: _____ Stage: _____ Cured / In Remission / NOT in remission
Treatment: _____

OTHER:

Cataracts	Y N	Glaucoma	Y N	Other: _____	

LAST MEDICAL EXAM

Date: _____ Doctor: _____ CXR/EKG: _____ # of Pregnancies/Miscarriages: _____

Last Pap Smear: _____ Last Colonoscopy: _____ Last Prostate Exam: _____ Last Mammo: _____

Last Blood Test: _____ Last Tetnus Shot: _____ Last Pneumonia Shot: _____ Are you pregnant now? _____

PREVIOUS HOSPITALIZATIONS/SURGERIES/SERIOUS ILLNESSES (Please include dates)

_____

_____

_____

MEDICATIONS – Prescription, Over-the-counter & Herbal (Please include dosage and frequency)

_____

_____

_____

ALLERGIES – History of skin reaction or other adverse reaction to:

Penicillin Demerol Aspirin Morphine Novacain Iodine Tylenol Cipro

Other drugs/medications: _____

Food allergies: _____ Environmental allergies: _____

SOCIAL HISTORY

Marital Status: single married divorced widowed **Tobacco Use:** never previously packs/day ____ quit date ____

Alcohol Use: never rarely social regular drinks per day ____ **Drug Use:** never type/frequency _____

Communicable Diseases: HIV/AIDS Sexually Transmitted Infection (type) _____ Other _____

FAMILY HISTORY

	Age		Diseases	If deceased, cause of death
Father	_____		_____	_____
Mother	_____		_____	_____
Siblings	_____	**M F**	_____	_____
	_____	**M F**	_____	_____
Children	_____	**M F**	_____	_____
	_____	**M F**	_____	_____

REVIEW OF SYSTEMS – Please indicate any personal history below:

Constitutional Symptoms
- Good general health lately……...y n
- Recent weight change……...y n
- Fatigue……..y n

Eyes
- Eye pain or drainage……y n
- Wear glasses/contact lenses…….y n
- Blurred or double vision……..y n

Ears/Nose/Mouth/Throat
- Hearing loss or ringing……y n
- Earaches or drainage……y n
- Sinus problem or congestion……y n
- Nose bleeds……..y n
- Mouth sores……..y n
- Tooth pain or bleeding gums……y n
- Bad breath or bad taste……y n
- Sore throat or voice change……..y n

Cardiovascular
- Chest pain or angina pectoris……y n
- Palpitations……y n
- Swelling of feet, ankles or hands..y n
- Varicose veins……...y n

Respiratory
- Chronic or frequent coughs……..y n
- Shortness of breath……...y n
- Spitting up blood……..y n
- Wheezing……..y n
- Frequent URI symptoms……..y n

Gastrointestinal
- Abdominal pain……y n
- Acid reflux/heartburn……y n
- Change in bowel movements……y n
- Nausea or vomiting……y n
- Frequent diarrhea……...y n
- Painful bowel movements/constipation..y n
- Rectal bleeding or blood in stool……y n

Genitourinary
- Frequent urination……..y n
- Burning or painful urination……...y n
- Blood in urine……y n
- Incontinence or dribbling……...y n
- High risk sexual behavior……...y n
- Sexual difficulty……y n
- Male – testicle pain……y n
- Female – pain with periods……y n
- Female – irregular periods……y n
- Female – vaginal discharge……y n

Musculoskeletal
- Joint pain, stiffness or swelling……..y n
- Muscle pain or cramps……...y n
- Back pain……...y n

Integumentary (skin, breast)
- Rash or itching……..y n
- Breast pain or lump……...y n
- Atypical mole(s)……..……..y n
- Warts……y n

Neurological
- Frequent or recurring headaches……y n
- Light headed or dizzy……y n
- Convulsions or seizures……..y n
- Numbness or tingling sensations……y n
- Tremors……...y n
- Memory Loss……..y n
- Weakness……y n

Psychiatric
- Anxiety……y n
- Feeling stressed or poor concentration..y n
- Depression……y n
- Insomnia……y n

Endocrine
- Excessive sweating……y n
- Glandular or hormone problems……y n
- Change in skin color……..y n
- Change in hair or nails……...y n
- Excessive thirst or urination……...y n
- Heat or cold intolerance……..y n
- Skin becoming dryer……..y n
- Change in hat or glove size……y n

Hematologic/Lymphatic
- Bleeding or bruising tendency……y n
- Enlarged glands……..y n
- Past transfusion……..y n

Allergic/Immunologic
- Seasonal allergies……...y n

To the best of my knowledge, the questions in this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____ _____ _____

Signature of Patient, Parent or Guardian | Signature of Doctor/P.A./A.R.N.P | Date