

Florida Medical Clinic
Internal Medicine and Pediatrics
Adult History Form

Name: _____ DOB: _____ Gender: M F
Ethnicity: _____ Email Address: _____

Primary contact number for lab results and appointment confirmation: _____

Preferred Pharmacy location and phone number: _____

MEDICAL HISTORY: Please list any past or current medical problems, including any reasons you may be on medication or hospitalizations

SURGICAL HISTORY: Please list any surgeries or procedures you have had

MEDICATIONS: Please list all medications, including vitamins, herbals, Over-the-Counter products

Name	Dose	How Often
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list all allergies and type of reaction:

SOCIAL HISTORY:

Are you currently smoking? Y N If so, how many packs per day? _____ How long? _____

Have you ever smoked? Y N If so, how many packs per day? _____ How long? _____

Do you drink alcohol? Y N If yes, how much do you drink? _____

Liquor: Per day: _____ Per week: _____ Per month: _____

Beer: Per day: _____ Per week: _____ Per month: _____

Wine: Per day: _____ Per week: _____ Per month: _____

Have you ever had a drinking problem? Y N

Do you use illegal street drugs? Y N If so, please list _____

What is your marital status? _____ How many children do you have? _____

Who lives in your household? _____

What is your occupation? _____

Do you travel outside of the USA? Y N If so, where? _____

Sexual Orientation: Heterosexual Homosexual Bi-Sexual or prefer not to discuss with provider

Do you exercise? _____ If so, how many times per week? _____

FAMILY HISTORY:

	Sex	Age	Deceased	Illnesses
Father: _____	N/A			
Mother: _____	N/A			
Sibling: _____				
Sibling: _____				
Children: _____				
Children: _____				

GYNECOLOGICAL HISTORY:

Name of GYN: _____

Last Pap: _____ History of abnormal Pap: Y N

Number of days in menstrual cycle: _____ Flow: Mild Moderate Heavy

Age of Menopause or Hysterectomy: _____

PREVENTATIVE HEALTH HISTORY:

Please indicate the last time the following were performed (or never):

Colonoscopy _____

Stool occult or blood testing: _____

Eye exam: _____

Mammogram: _____

Mammogram: _____

Dexa Scan (Bone Density): _____

Last stress test _____

Last EKG: _____

Tetanus vaccine: _____

Pneumovax: _____

Hep B vaccine: _____

Hep A vaccine: _____

Zostravax: _____

Do you have a living will? _____ if so, please provide a copy with our office.

Signature: _____ Date: _____