Florida Medical Clinic
Your life. Our specialty.

Medical History

Alejandro Cintas, M.D.

Medical - ☐ None *(High Blood Pressure, Diabetes, Cancer, Heart Disease, etc.)*

Pregnancy History

Year	Sex	Complications

Surgical - ☐ None *(Tonsillectomy; Appendectomy, Hysterectomy, Hernia, etc. – Please enter year surgery was done, if known.)*

Allergies to medications? ☐ None (*If Yes, please explain type of reaction, i.e. hives, wheezing, upset stomach, swelling, etc.)*

Last Immunizations: FLU PNEU TETANUS OTHER

Current prescription medications: ☐ None

Name of drug	mg dose	# tablets	# times per day

Additional **current** prescription medications: ☐ None

Name of drug	mg dose	# tablets	# times per day

Current Non-Prescription Medication? ☐ None *(Aspirin, Tylenol, Ibuprofen, Aleve, vitamins, anti-acids, herbals)*

Family History

Father: ☐ Living - Age ______ ☐ Deceased; Age at Death ______ (Cause) ____________
Mother: ☐ Living - Age ______ ☐ Deceased; Age at Death ______ (Cause) ____________
Siblings: ☐ Number Living ______ Number Deceased ______ (Cause) ____________

List other illnesses in your family *(Example – Diabetes, heart disease, colon, breast, or prostate cancer, arthritis, depression, etc.)*

(Family Member)		(Illness)	(Family Member)		(Illness)	(Family Member)		(Illness)
	=			=			=	
	=			=			=	

Social History

Caffeine? ☐ Yes ☐ No If yes, how much? ____________
Smoke? ☐ Yes ☐ No If yes, how much? _____ # of packs/day _____ # of years When did you stop smoking? ______
Alcohol? ☐ Yes ☐ No If yes, how much? ____________
Occupation: ____________ ☐ Retired Significant prior industrial or agricultural exposures? ☐ Yes ☐ No
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed Number of Children ______ ☐ None
Exercise Regularly? ☐ Yes ☐ No If yes, how frequently? ____________

Patient Name Date of Birth