CareMed of Florida
PATIENT HISTORY FORM

Patient's Name: _____ Today's Date: _____

Social Security Number: _____ Date of Birth: _____

Past Medical History

Previous Physician's name: _____ Date of last exam: _____

Have you ever been hospitalized? ☐Yes ☐No If yes, what for? _____

Have you ever been tested for hepatitis A, B or C? ☐Yes ☐No Which hepatitis virus?_____

Have you been vaccinated for hepatitis B? ☐Yes ☐No If yes, date vaccine series completed _____

Have you been vaccinated for hepatitis A? ☐Yes ☐No If yes, date vaccine series completed _____

Last Tuberculosis (TB) Screening? _____ Result of TB screening: ☐Positive ☐Negative

If positive TB screen, date of last chest x-ray: _____ Result of chest x-ray: ☐Positive ☐Negative

Have you had a sexually transmitted disease? ☐Yes ☐No Diagnosis: _____

Which of the following conditions are you currently being treated or have been treated for in the past (please check)

☐Heart disease / Murmur / Angina	☐Shortness of breathe	☐Eye disorder / Glaucoma	☐Diabetes
☐High cholesterol	☐Asthma	☐Seizures	☐Kidney / Bladder problems
☐High blood pressure	☐Lung problems / cough	☐Stroke	☐Liver problems / Hepatitis
☐Low blood pressure	☐Sinus problems	☐Headaches / Migraines	☐Arthritis
☐Heartburn (reflux)	☐Seasonal allergies	☐Neurological problems	☐Cancer
☐Anemia or blood problems	☐Tonsillitis	☐Depression / Anxiety	☐Ulcers/colitis
☐Swollen ankles	☐Ear problems	☐Psychiatric care	☐Thyroid problems

Please describe any current or past medical treatment not listed above

_____

_____

Please list your past surgeries

_____

_____

Allergies

Are you allergic to penicillin or any other drugs? ☐Yes ☐No

Please list: _____

Medications

Please list: _____

_____

Social and Preventive History

Do you currently smoke or chew tobacco? ☐Yes ☐No If no, have you in the past? ☐Yes ☐No
How many packs per day? _____

Do you drink alcohol, beer, or wine? ☐Yes ☐No If no, have you in the past? ☐Yes ☐No
How many drinks per week? _____

Do you currently drink coffee and/or tea? ☐Yes ☐No If yes, how many cups per day? _____

Do you exercise daily/weekly? ☐Yes ☐No

Do you use seatbelts while driving? ☐Yes ☐No Do you wear a helmet while riding a bike? ☐Yes ☐No

Family History

	Living	Age (or age at death)	List serious illnesses
Mother	☐Yes ☐No	_____	_____
Father	☐Yes ☐No	_____	_____
Sisters	☐Yes ☐No	_____	_____
	☐Yes ☐No	_____	_____
	☐Yes ☐No	_____	_____
Brothers	☐Yes ☐No	_____	_____
	☐Yes ☐No	_____	_____
	☐Yes ☐No	_____	_____

Has any member of your family (including children and parents) had any of the following illnesses:

Illness	Which family member?
Anemia or Blood disease	_____
Cancer	_____
Diabetes	_____
Glaucoma	_____
Heart disease	_____
High blood pressure	_____
HIV disease / AIDS	_____
Mental Illness / Depression	_____
Stroke	_____
Other serious illness	_____

Females: Gynecological History

How many times have you been pregnant? _____ Date of last Pap Smear: _____

Have you had an abnormal Pap Smear? ☐Yes ☐No Diagnosis: _____ Follow up: _____

Have you had a sexually transmitted disease? ☐Yes ☐No Diagnosis: _____
Date of last mammogram: _____ Mammogram results: _____

Have you ever had a breast biopsy? ☐Yes ☐No Biopsy results: _____

By signing below, I hereby certify that to the best of my knowledge all the information I have furnished on this form is complete, true and accurate.

Patient/Legal Guardian Signature _____ **Date** _____