INTERNAL MEDICINE & HEALTHY LIFESTYLE

9486 Narcoossee Rd, Orlando FL, 32827
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PATIENT INFORMATION

Name : _____ Date of Birth: _____
First Middle Last

Home Phone : _____ Cell Phone :_____ Sex: [ ] Male [ ] Female

Address: _____
City, State Zip Code

Mailing Address:_____
(if is different from physical address)

Email:_____ Status: [ ] Single [ ] Divorced [ ] Married
[ ] Widowed [ ] Separated [ ] Partner

(Only Female)= Pregnant [ ] Yes [ ] No, If yes, How many kids?_____
Language: [ ] English [ ]Spanish other:_____ Ethnicity: [ ] Hispanic [ ] Not Hispanic

Patient's Occupation: _____ Employer's:_____
Current Employer': _____( ) _____
Address Phone

Emergency Contact :
Name : _____ Relationship:_____
Phone : _____

How did you hear about us ?
[ ] Friend [ ]Family [ ]Patient [ ] Internet [ ] Social Media [ ] Physician/ Nurse [ ] Other:_____

INSURANCE INFORMATION

[ ] NO INSURANCE

PRIMARY INSURANCE

Member ID: _____ Insurance Name:_____
Principal Subscriber Name:_____ Relationship to Patient:_____
Subscriber Date of Birth:_____ Phone Number :_____

SECONDARY INSURANCE (If applicable)

Member ID: _____ Insurance Name:_____
Principal Subscriber Name:_____ Relationship to Patient:_____
Subscriber Date of Birth:_____ Phone Number :_____

PHARMACY INFORMATION:

Name :
Address:
Phone :

OFFICE PERSONAL ONLY:

B/P= _____/_____ HR=_____ OXG=_____ TEMP=_____ WT=_____

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PATIENT NAME:_____

NEW PATIENT HEALTH QUESTIONNAIRE

Height :_____ Weight :_____

ALLERGY : [ ] NO [ ] YES. If yes, complete the following :

Medicine	**Reaction**	**General**	**Reaction**
Aspirin		*Latex*	
Erythromycin		*Adhesive*	
NSAIDs		*Other*	
Penincillin			
Sulfa			

SOCIAL HISTORY :

Do you Smoke? Yes [ ] How many a day ? =
[ ] No [ ] Former smoker. When did you quit? =
Do you drink alcohol ? [ ] Yes [ ] No . If yes, Type= Amount per day=
Do you use ilegal drugs? [ ]Yes , [ ] No. If yes,What kind of substance?
Exercise? [ ] Yes [ ] No. If yes,Type: Frequency:
Do you drink coffee I ? [ ] Yes [ ] No Amount per day=

PAST MEDICAL HISTORY :

[ ] Bleeding or Clotting disorder	[ ] TIA (transient ischemic attack)	[ ] Myocardial infarction (heart attack)	[ ]Hypertension / High blood pressure
[ ]Coronary artery disease	[ ] Stroke	[ ] Diabetes - Insulin [ ] yes [ ] no	[ ] Hypercholesterolemia
[ ]Thyroid diseases	[ ] Osteoporosis	[ ]Kidney diseases	[ ]Sleep apnea. If so do you use CPAP?_____
[ ]Pulmonary embolism	[ ]Chronic bronchitis	[ ]Asthma	[ ]COPD
[ ] GERD/ Reflux	[ ]Gastric Ulcer	[ ] Bowel Diseases	[ ]Degenerative disk diseases
[ ]Rheumatoid Arthritis	[ ] Psoriasis	[ ]Osteoarthritis	[ ]Osteoporosis
[ ] Major Depression	[ ] Anxiety disorder	[ ]Cancer Type:_____	[ ] HIV
[ ] Hepatitis	[ ]Join Infection	Other :	Other:

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FAMILY HISTORY :

Conditions	Father	Mother	F.Grandpa	F.Grandma	M.Grandpa	M.Grandma	Brother	Sister	Son	Daughter
Cancer - Type										
Heart Disease										
Diabetes										
Depression										
Psychiatric										
High Blood pressure										
Cholesterol										
Asthma										
Lung Disease										
Glaucoma										
Kidney Disease										

SURGICAL HISTORY (INCLUDING THE YEAR):

HOSPITALIZATION / ER VISIT (THE LAST 3 MONTHS) :

CURRENT MEDICATIONS:

Medication	Dose	Frequency	Medication	Dose	Frequency

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REVIEW OF SYSTEMS :

GENERAL: [ ] Good general health [ ] Loss of appetite [ ] Weakness [ ] Dizziness [ ] Fever [ ] Fatigue [ ] Feeling tired all the time [ ] Weight gain of more than 10 lbs [ ] Weight loss of more than 10 lbs **SKIN:** [ ] Rashes [ ] Bruise easily **MUSCULOSKELETAL:** [ ] Joint pain [ ] Muscle pain /Weakness **ENDOCRINE:** [ ] Thyroid problems [ ] Appetite changes [ ] Diabetes **BLOOD:** [ ] Blood clot [ ] Prolonged bleeding [ ] Spontaneous bleeding [ ] Enlarged lymph node	**HEENT:** [ ] Hearing changes [ ] Blurry vision [ ] Vision Changes [ ] Glasses [ ] Sinusitis [ ] Neck pain/mass [ ] Difficulty swallowing **RESPIRATORY:** [ ] Cough persistent [ ]Shortness of breath [ ] Wheezing **CARDIOVASCULAR:** [ ] Chest pain [ ] Palpitations [ ] Irregular heartbeat [ ] Heart Murmur **PSYCHOLOGY:** [ ] Anxiety [ ] Change in sleep pattern [ ] Depression [ ] Memory problems	**GASTROINTESTINAL:** [ ] Diarrrhea [ ] Constipation [ ] Nausea/Vomiting [ ] Abdominal pain [ ] Blood in stool **NEUROLOGICAL :** [ ] Dizziness [ ] Tremor [ ] Numbness [ ] Headaches/MIgraine [ ] Convulsions/ seizures **GENITOURINARY:** [ ] Blood in urine [ ] Painful Urination [ ] Increased frequency of urination at night [ ] Erectile Problems [ ] Kidney stones **OB/GYN (Females only) :** [ ] Pregnancy _____ [ ] Abortions _____ [ ] Surgeries _____

PREVENTIVE HEALTH SCREENING:

TEST :	DATE / YEAR :	WHERE :
Mammogram (female)		
PAP smear (female)		
Colonoscopy / Sigmoid screening		
Eye Screening		
Bloodwork		
PSA (male)		
Bone density (DEXA)		
Stress test / EKG		

IMMUNIZATIONS:	DATE / YEAR:	IMMUNIZATIONS :	DATE/YEAR:
Tetanus		Zoster (shingles vaccine)	
Hepatitis		Covid Vaccine	
Tuberculosis (PPD) test			
Flu shot			
Pneumonia			