



7125 Hoffner Ave ,Ste #102 Orlando FL, 32822

Phone : 407-203-1880

ramosmd@internalmedhl.com

PATIENT INFORMATION

*Name : _____ *Date of Birth: _____
First Middle Last

*Principal Phone # : _____ - _____ - _____ Sex: [] Male [] Female *S. S # : _____

Additional Phone # : _____ - _____ - _____

*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,(Weeks) _____ ,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: _____

*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	Medicine	Reaction
Aspirin		Latex	
Erythromycin		Adhesive	
NSAIDs		Other	
Penicillin			
Sulfa			

SOCIAL HISTORY :

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

PAST MEDICAL HISTORY :

<input type="checkbox"/> Bleeding or Clotting disorder	<input type="checkbox"/> TIA (transient ischemic attack)	<input type="checkbox"/> Myocardial infarction (heart attack)	<input type="checkbox"/> Hypertension / High blood pressure
<input type="checkbox"/> Coronary artery disease	<input type="checkbox"/> Stroke	<input type="checkbox"/> Diabetes - Insulin <input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> Hypercholesterolemia
<input type="checkbox"/> Thyroid diseases	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Kidney diseases	<input type="checkbox"/> Sleep apnea. If so do you use CPAP? _____
<input type="checkbox"/> Pulmonary embolism	<input type="checkbox"/> Chronic bronchitis	<input type="checkbox"/> Asthma	<input type="checkbox"/> COPD
<input type="checkbox"/> GERD/ Reflux	<input type="checkbox"/> Gastric Ulcer	<input type="checkbox"/> Bowel Diseases	<input type="checkbox"/> Degenerative disk diseases
<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Psoriasis	<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Major Depression	<input type="checkbox"/> Anxiety disorder	<input type="checkbox"/> Cancer Type: _____	<input type="checkbox"/> HIV
<input type="checkbox"/> Hepatitis	<input type="checkbox"/> 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
<i>Cancer - Type</i>										
<i>Heart Disease</i>										
<i>Diabetes</i>										
<i>Depression</i>										
<i>Psychiatric</i>										
<i>High Blood pressure</i>										
<i>Cholesterol</i>										
<i>Asthma</i>										
<i>Lung Disease</i>										
<i>Glaucoma</i>										
<i>Kidney Disease</i>										

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