

WEST FLORIDA MEDICAL GROUP

MEDICAL HISTORY

Date _____

Name _____ Age _____ Single _____ Divorced _____
 Address _____ Married _____ Widow(er) _____
 Occupation _____ Spouse's Name _____
 Phone # Home _____ Work _____ Spouse's Occupation _____
 Reason for today's appointment _____

PERSONAL MEDICAL HISTORY

Illness (please list past major medical illnesses)

Surgeries

MEDICATIONS: List any drug or medication that you take

ALLERGIES: List any known allergies

Latex Allergy _____ Yes _____ No _____

HABITS: Do you

Exercise regularly? yes no

Use alcoholic bev.? yes no

Type of activity _____

every day? yes no

Smoke? yes no

how much? _____

WOMEN ONLY

Age at onset of menstruation _____

Pregnancies: how many? _____

Date of last period _____

Children born alive _____

Is it possible you may be pregnant? _____ yes no

Stillbirths? _____

Menstrual cycle _____ days _____ (from start to stop)

Prematures? _____

Cycle regular irregular

Cesarean Sections? _____

Usual duration of flow _____ days

Miscarriages? _____

Flow Heavy Medium Light

Complications? Yes No

Cramps Severe Mild None

Date of last pap smear: _____

Date of last mammogram: _____

FAMILY HISTORY	Age	Health	Age at Death	Cause at Death	Any blood relative had	Whom
Father					Cancer	no yes
Mother					Tuberculosis	no yes
Brother or Sister					Diabetes	no yes
					Heart Trouble	no yes
					Hypertension	no yes
Husband or Wife					Stroke	no yes
Son or Daughter					Epilepsy	no yes
					Mental Illness	no yes
					Suicide	no yes
					Birth defects	no yes
					Thyroid disease	no yes
					Alcoholism	no yes

WERE YOU REFERRED TO THE CLINIC? If so, by whom (name & address)? _____

Signature _____