# 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

Use alcoholic bev.? ..... yes no

every day? ..... yes no

Smoke? ..... yes no

how much? _____

Exercise regularly? ..... yes no

Type of activity _____

## WOMEN ONLY

Age at onset of menstruation _____

Date of last period _____

Is it possible you may be pregnant? _____ yes no

Menstrual cycle _____ days _____ (from start to stop)

Cycle regular irregular

Usual duration of flow _____ days

Flow Heavy Medium Light

Cramps Severe Mild None

Pregnancies: how many? _____

Children born alive _____

Stillbirths? _____

Prematures? _____

Cesarean Sections? _____

Miscarriages? _____

Complications? Yes No

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