NORTH SEMINOLE
Family Practice & Sports Medicine

As a new patient, please fill out the information found below to the best of your ability.

Patient# _____ Physician _____ Date _____

Patient Name _____ Chief Complaint _____

HISTORY OF PRESENT ILLNESS

Location _____
(Where is the pain/problem?)

Quality _____
(Example: normal versus abnormal color, activity, etc.)

Severity _____
(How severe is the pain/problem on a scale of 1 – 5 [5 being the most severe])

Duration _____
(How long have you had this pain/problem, or when did it start?)

Timing _____
(Does this pain/problem occur at a specific time?)

Context _____
(Where were you at the onset of this pain/problem?)

Associated _____

Modifying Factors _____

Signs/ Symptoms _____

(What other associated problems have you been having?)

(What makes the pain/problem worse or better? Have you had previous episodes?)

PATIENT MEDICAL HISTORY

Have you ever had the following (check "no" or "yes," leave blank if uncertain):

Measles	☐ No	☐ Yes	Venereal Disease	☐ No	☐ Yes	Blood or Plasma Transfusions	☐ No	☐ Yes	Bronchitis	☐ No	☐ Yes
Mumps	☐ No	☐ Yes	Anemia	☐ No	☐ Yes				Mitral Valve Prolapse	☐ No	☐ Yes
Chicken Pox	☐ No	☐ Yes	Bladder Infections	☐ No	☐ Yes	Back Trouble	☐ No	☐ Yes			
Whooping Cough	☐ No	☐ Yes	Epilepsy	☐ No	☐ Yes	High or Low Blood Pressure	☐ No	☐ Yes	Stroke	☐ No	☐ Yes
Scarlet Fever	☐ No	☐ Yes	Migraine Headaches	☐ No	☐ Yes				Hepatitis	☐ No	☐ Yes
Diphtheria	☐ No	☐ Yes	Tuberculosis	☐ No	☐ Yes	Hemorrhoids	☐ No	☐ Yes	Ulcer	☐ No	☐ Yes
Smallpox	☐ No	☐ Yes	Diabetes	☐ No	☐ Yes	Asthma	☐ No	☐ Yes	Kidney Disease	☐ No	☐ Yes
Pneumonia	☐ No	☐ Yes	Cancer	☐ No	☐ Yes	Hives or Eczema	☐ No	☐ Yes	Thyroid Disease	☐ No	☐ Yes
Rheumatic Fever	☐ No	☐ Yes	Polio	☐ No	☐ Yes	AIDS or HIV+	☐ No	☐ Yes	Bleeding Tendency	☐ No	☐ Yes
Heart Disease	☐ No	☐ Yes	Glaucoma	☐ No	☐ Yes	Infectious Mono	☐ No	☐ Yes	Any Other Disease	☐ No	☐ Yes
Arthritis	☐ No	☐ Yes	Hernia	☐ No	☐ Yes	Date of last chest x-ray: _____			(please list) _____		

Previous Hospitalizations/Surgeries/Serious Illnesses	When	Hospital, City, State

Medications (include nonprescription):

PATIENT SOCIAL HISTORY

Marital Status:	☐ Single	☐ Married	☐ Separated	☐ Divorced	☐ Widowed
Use of alcohol:	☐ Never	☐ Rarely	☐ Moderate	☐ Daily	
Use of tobacco:	☐ Never	☐ Previously, but quit: _____		☐ Current packs/day _____	
Use of drugs:	☐ Never	☐ Type/frequency: _____			
Excessive exposure at home or work to:	☐ Fumes	☐ Dust	☐ Solvents	☐ Airborne particles	☐ Noise

FAMILY MEDICAL HISTORY

	Age	Diseases	If deceased, cause of death
Father			
Mother			
Siblings			
Spouse			
Children			

Over Please

REVIEW OF SYSTEMS

Please indicate any personal history below

CONSTITUTIONAL

Good general health lately	☐ No	☐ Yes
Recent weight change	☐ No	☐ Yes
Fever	☐ No	☐ Yes
Fatigue	☐ No	☐ Yes
Headaches	☐ No	☐ Yes

EYES

Eye disease or injury	☐ No	☐ Yes
Wear glasses/contact lenses	☐ No	☐ Yes
Blurred or double vision	☐ No	☐ Yes

EAR/NOSE/MOUTH/THROAT

Hearing loss or ringing	☐ No	☐ Yes
Earaches or drainage	☐ No	☐ Yes
Chronic sinus problems or rhinitis	☐ No	☐ Yes
Nose bleeds	☐ No	☐ Yes
Mouth sores	☐ No	☐ Yes
Bleeding gums	☐ No	☐ Yes
Bad breath or bad taste	☐ No	☐ Yes
Sore throat or voice change	☐ No	☐ Yes
Swollen glands in neck	☐ No	☐ Yes

CARDIOVASCULAR

Heart trouble	☐ No	☐ Yes
Chest pain or angina pectoris	☐ No	☐ Yes
Palpitation	☐ No	☐ Yes
Shortness of breath while walking or lying flat	☐ No	☐ Yes
Swelling of feet, ankles, or hands	☐ No	☐ Yes

RESPIRATORY

Chronic or frequent coughs	☐ No	☐ Yes
Spitting up blood	☐ No	☐ Yes
Shortness of breath	☐ No	☐ Yes
Wheezing	☐ No	☐ Yes

GASTROINTESTINAL

Loss of appetite	☐ No	☐ Yes
Change in bowel movements	☐ No	☐ Yes
Nausea or vomiting	☐ No	☐ Yes
Frequent diarrhea	☐ No	☐ Yes
Painful bowel movements or constipation	☐ No	☐ Yes
Rectal bleeding or blood in stool	☐ No	☐ Yes
Abdominal pain	☐ No	☐ Yes

GENITOURINARY

Frequent Urination	☐ No	☐ Yes
Burning or painful urination	☐ No	☐ Yes
Blood in urine	☐ No	☐ Yes
Change in force of strain when urinating	☐ No	☐ Yes
Incontinence or dribbling	☐ No	☐ Yes
Kidney stones	☐ No	☐ Yes
Sexual difficulty	☐ No	☐ Yes
Male – testicle pain	☐ No	☐ Yes
Female – pain with periods	☐ No	☐ Yes
Female – irregular periods	☐ No	☐ Yes
Female – vaginal discharge	☐ No	☐ Yes
Female – # of pregnancies: _____		
Female – # of miscarriages: _____		
Female – date of last pap smear: _____		

MUSCULOSKELETAL

Joint pain	☐ No	☐ Yes
Joint stiffness or swelling	☐ No	☐ Yes
Weakness of muscles or joints	☐ No	☐ Yes
Muscle pain or cramps	☐ No	☐ Yes
Back pain	☐ No	☐ Yes
Cold extremities	☐ No	☐ Yes
Difficulty in walking	☐ No	☐ Yes

INTEGUMENTARY (SKIN, BREAST)

Rash or itching	☐ No	☐ Yes
Change in skin color	☐ No	☐ Yes
Change in hair or nails	☐ No	☐ Yes
Varicose veins	☐ No	☐ Yes
Breast pain	☐ No	☐ Yes
Breast lump	☐ No	☐ Yes
Breast discharge	☐ No	☐ Yes

NEUROLOGICAL

Frequent or recurring headaches	☐ No	☐ Yes
Light headed or dizzy	☐ No	☐ Yes
Convulsions or seizures	☐ No	☐ Yes
Numbness or tingling sensations	☐ No	☐ Yes
Tremors	☐ No	☐ Yes
Paralysis	☐ No	☐ Yes
Head injury	☐ No	☐ Yes

PSYCHIATRIC

Memory loss or confusion	☐ No	☐ Yes
Nervousness	☐ No	☐ Yes
Depression	☐ No	☐ Yes
Insomnia	☐ No	☐ Yes

ENDOCRINE

Glandular or hormone problem	☐ No	☐ Yes
Excessive thirst or urination	☐ No	☐ Yes
Heat or cold intolerance	☐ No	☐ Yes
Skin becoming dryer	☐ No	☐ Yes
Change in hat or glove size	☐ No	☐ Yes

HEMATOLOGIC/LYMPHATIC

Slow to heal after cuts	☐ No	☐ Yes
Bleeding or bruising tendency	☐ No	☐ Yes
Anemia	☐ No	☐ Yes
Phlebitis	☐ No	☐ Yes
Past transfusion	☐ No	☐ Yes
Enlarged glands	☐ No	☐ Yes

ALLERGIC/IMMUNOLOGIC

History of skin reaction or other adverse reaction to:

Penicillin or other antibiotics	☐ No	☐ Yes
Morphine, Demerol, or other narcotics	☐ No	☐ Yes
Novocaine or other anesthetics	☐ No	☐ Yes
Aspirin or other pain remedies	☐ No	☐ Yes
Tetanus antitoxin or other serums	☐ No	☐ Yes
Iodine, methiolate or other antiseptics	☐ No	☐ Yes

Other drugs/medications: _____

_____

_____

_____

_____

Known food allergies: _____

_____

_____

_____

Environmental allergies: _____

_____

_____

_____

AUTHORIZATION & RELEASE

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

X _____ _____

Signature Date

Doctor's Review: _____

_____

_____

_____

_____

_____

_____

_____ _____

Signature of Doctor Date