SW FLORIDA REGIONAL MEDICAL CENTER

Family Medical History ❏Noncontributory

Age

Diseases

If Deceased, Cause of Death

**Comprehensive Patient History Form**

Patient Name: DOB: Today’s Date:

Describe your main problem

**PREFERED PHARMACY:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |
| --- | --- |
| Where is your problem located?  | Have you ever had the following? |
| How severe is your problem?  | Diabetes………………. yes no |
| Rate the severity of the problem: Mild > 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 < Severe | Hypertension…………. yes no |
| How long have you had this problem?  | Cancer………………… yes no Stroke…………………. yes no |
| When does this problem occur?  | Heart trouble………….. yes no |
| Can you attribute the cause of this problem to anything?  | Arthritis/gout…………. yes no Convulsions…………… yes no |
|  | Bleeding tendency…….. yes no |
| Are there other symptoms associated with the problem?  | Acute infections……….. yes no Venereal disease………. yes no |
|  | STD’s…………………. yes no |
|  | Hereditary defects……... yes no |
| What makes this problem worse or better?  |  |
|  |
| List previous hospitalizations/Surgeries/Serious Injuries When? | **What Medications are you taking?** |
| **N/A** |
| 1)  |
| 2)  |
| 3)  |
| 4)  |
| 5)  |
| Patient Social History ❏NoncontributoryMarital Status: ❏Single ❏Married ❏Separated ❏Divorced ❏Widowed Use of alcohol: ❏Never ❏Rarely ❏Socially ❏Daily Use of tobacco: ❏Never ❏Previously quit ❏ Current packs per day Use of Drugs: ❏Never ❏Type/Frequency Excessive exposure at home or work to: ❏Fumes ❏Dust ❏Solvents ❏Noise❏Chemicals ❏Smoke ❏Animal Hair |
| 6)  |
| 7)  |
| 8)  |
| 9)  |
| 10)  |
| 11)  |
| 12)  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Father Mother Siblings |     |  |     |  |     |
| Spouse |  |  |  |  |  |
| Children |  |  |  |  |  |

**SW FLORIDA REGIONAL MEDICAL CENTER**

**PLEASE ANSWER ALL QUESTIONS**

***Have you had any of the following during the past three months?***

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **CONSTITUTIONAL**Good general health lately…………………….. | No | Yes |  | **MUSCULOSKELETAL**Joint pain……………….……………………… | No | Yes |
| Recent weight change…………………………. | No | Yes |  | Joint stiffness or swelling……………………… | No | Yes |
| Fever…………………………………………... | No | Yes |  | Weakness of muscles or joints………………… | No | Yes |
| Fatigue………………………………………… | No | Yes |  | Muscle pain or cramps………………………… | No | Yes |
| Headaches……………………………………... | No | Yes |  | Back pain………………………………………. | No | Yes |
| **EYES**Eye disease or injury………………………….. | No | Yes |  | Cold extremities………………………………... Difficulty in walking…………………………… | No No | Yes Yes |
| Wear glasses/contact lens…………………….. | No | Yes |  | **SKIN** |  |  |
| Blurred or double vision……………………… | No | Yes |  | Rash or itching…………………………………. | No | Yes |
| Glaucoma……………………………………... | No | Yes |  | Change in skin color…………………………… | No | Yes |
| **ENT**Hearing loss…………………………………... | No | Yes |  | Change in hair or nails…………………………. Varicose veins………………………………….. | No No | Yes Yes |
| Ringing in the ears……………………………. | No | Yes |  | Breast pain……………………………………… | No | Yes |
| Earaches or drainage………………………….. | No | Yes |  | Breast lump…………………………………….. | No | Yes |
| Sinus problems………………………………...Nose bleeds…………………………………… | NoNo | YesYes |  | Breast discharge…………………………………**NEUROLOGICAL** | No | Yes |
| Mouth sores…………………………………… | No | Yes |  | Frequent or recurring headaches………………... | No | Yes |
| Bleeding gums………………………………… | No | Yes |  | Light headed or dizzy…………………………... | No | Yes |
| Bad breath or bad taste………………………... | No | Yes |  | Convulsions or seizures………………………… | No | Yes |
| Sore throat or voice change……………………. | No | Yes |  | Numbness or tingling sensations……………….. | No | Yes |
| Swollen glands in neck………………………… | No | Yes |  | Tremors………………………………………… | No | Yes |
| **CARDIOVASCULAR**Heart trouble…………………………………… | No | Yes |  | Paralysis………………………………………... Stroke…………………………………………… | No No | Yes Yes |
| Chest pains……………………………………..Sudden heart beat changes…………………….. | NoNo | YesYes |  | Head injury………………………………………**PSYCHIATRIC** | No | Yes |
| Swelling of feet, ankles or hands……………… | No | Yes |  | Memory loss or confusion……………………… | No | Yes |
| **RESPIRATORY**Frequent coughing……………………………... | No | Yes |  | Nervousness……………………………………. Depression……………………………………… | No No | Yes Yes |
| Spitting up blood……………………………….Shortness of breath…………………………….. | NoNo | YesYes |  | Sleep problems………………………………….**ENDOCRINE** | No | Yes |
| Asthma or wheezing…………………………… | No | Yes |  | Glandular or hormone problem………………… | No | Yes |
| **GASTROINTESTINAL**Loss of appetite………………………………… | No | Yes |  | Thyroid disease………………………………… Diabetes………………………………………… | No No | Yes Yes |
| Change in bowel movements………………….. | No | Yes |  | Excessive thirst or urination…………………… | No | Yes |
| Nausea or vomiting……………………………. | No | Yes |  | Heat or cold intolerance……………………….. | No | Yes |
| Frequent diarrhea………………………………. | No | Yes |  | Dry skin………………………………………... | No | Yes |
| Painful bowel movements or constipation……..Blood in stool………………………………….. | NoNo | YesYes |  | Change in hat or glove size…………………….**HEMATOLOGIC/LYMPHATIC** | No | Yes |
| Stomach pain…………………………………… | No | Yes |  | Slow to heal after cuts…………………………. | No | Yes |
| **GENITOURINARY**Frequent urination……………………………… | No | Yes |  | Easily bruise or bleed………………………….. Anemia…………………………………………. | No No | Yes Yes |
| Burning or painful urination…………………… | No | Yes |  | Phlebitis………………………………………… | No | Yes |
| Blood in urine………………………………….. | No | Yes |  | Past transfusion………………………………… | No | Yes |
| Change of force of strain when urinating………Incontinence or dribbling………………………. | NoNo | YesYes |  | Enlarged glands…………………………………**ALLERGIC/IMMUNOLOGIC** | 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 – # pregnancies # miscarriages Female – date of last pap smear Female – findings of last pap smear ❏Normal ❏AbnormalDate: |  | History of skin reaction or other adverse reactions Penicillin or other antibiotics………… Morphine, Demerol or other narcotics.. Novocaine or other anesthetics………. Aspirin or other pain remedies………. Tetanus antitoxin or other serums…… Iodine, methiolate or other antiseptic…Other drugs/medications Known food allergies | to:No YesNo YesNo YesNo YesNo YesNo Yes |

Patient Signature: Physician Signature:

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| --- | --- | --- | --- | --- | --- | --- |
| WT | HT | B/P | H/R | R/R  | TEMP. | 02 SAT |
|  |  |  |  |  |  |  |