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Certified Family Practice

Chief Complaint: State why you want to see the practitioner.

_____

_____

Allergies: include medications, food, and environmental allergies:

Allergy:

_____

Reaction:

_____

❑ **No known drug allergies**

Current Medications: please bring in all prescription and over-the-counter medications

Medication	Dosage	How Many Times A Day

Preferred Pharmacy:

Local Pharmacy: _____

Location: _____ Phone Number: _____

Mail-in Pharmacy: _____ Phone Number: _____

Patient Past Medical History:

Respiratory:
- ❑ Asthma
- ❑ COPD
- ❑ Sleep Apnea
- ❑ Anaphylaxis

Cardiovascular:
- ❑ Heart Disease
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Atrial Fibrillation
- ❑ Blood Clots

Renal/GU:
- ❑ BPH (enlarged prostate)
- ❑ Kidney Disease
  Stage _____

Gastrointestinal:
- ❑ Gastric Reflux
- ❑ Ulcers
- ❑ Inflammatory Bowel Disease
- ❑ Lactose Intolerance
- ❑ Celiac Disease

ENT:
- ❑ Glaucoma
- ❑ Cataracts
- ❑ Septal Deviation
- ❑ Nasal Polyps
- ❑ TMJ

Neuro:
- ❑ Dementia
- ❑ Migraine
- ❑ Seizure
- ❑ Stroke
- ❑ Depression
- ❑ Anxiety

Autoimmune:
- ❑ Lupus
- ❑ Rheumatoid Arthritis
- ❑ Sjogern's Disease
- ❑ Multiple Sclerosis
- ❑ Psoriasis
- ❑ Vasculitis

Other:
- ❑ Diabetes
- ❑ Osteopenia
- ❑ Osteoporosis
- ❑ Thyroid Disease
- ❑ Anemia
- ❑ B12 Deficiency
- ❑ Cancer (past or present)

Past Surgical History:

Surgeries:

_____

_____

Approximate Date: _____

Family History: List which family member.

Cancer: _____ Stroke: _____

Heart Attack: _____ High Blood Pressure: _____

Hypertension: _____ Autoimmune Disease: _____

Asthma: _____ Allergies: _____

Review of Symptoms: Check any symptom below that describes a problem you are having.

Allergic:
- ❑ Itchy Ears
- ❑ Itchy Eyes
- ❑ Itchy Nose
- ❑ Nasal Drainage
- ❑ Nasal Congestion
- ❑ Excessive Sneezing

Eyes:
- ❑ Double Vision
- ❑ Blurred Vision
- ❑ Difficulty with Vision

Mouth:
- ❑ Itchy Mouth
- ❑ Mouth Lesions
- ❑ Teeth Problems
- ❑ Swelling
- ❑ Decreased Taste

Sinus:
- ❑ Post Nasal Drip
- ❑ Nasal Congestion
- ❑ Sinus Pressure
- ❑ Sinus Headache
- ❑ Sinus Infections
- ❑ Decreased Smell
- ❑ Sinus Infections

Constitutional:
- ❑ Fever
- ❑ Weight Loss
- ❑ Trouble Sleeping
- ❑ Night Sweats

Ears:
- ❑ Ear Pain
- ❑ Pressure in Ears
- ❑ Difficulty Hearing

Throat:
- ❑ Itchy Throat
- ❑ Throat Clearing
- ❑ Phlegm in Throat
- ❑ Throat Swelling

Cardiovascular:
- ❑ Fainting
- ❑ Chest Pain
- ❑ Palpitations

Gastrointestinal:
- ❑ Diarrhea
- ❑ Nausea
- ❑ Vomiting
- ❑ Constipation
- ❑ Heartburn
- ❑ Stomach Pain

Skin:
- ❑ Hives
- ❑ Swelling
- ❑ Skin Rash
- ❑ Skin Lesion
- ❑ Skin Itching

Musculoskeletal:
- ❑ Fatigue
- ❑ Dizziness
- ❑ Weakness
- ❑ Muscle Pain
- ❑ Muscle Aches

Respiratory:
- ❑ Coughing
- ❑ Wheezing
- ❑ Chest Tightness
- ❑ Chest Congestion
- ❑ Trouble Breathing
- ❑ Excessive Sputum
- ❑ Shortness of Breath

Please describe any symptom(s) not listed above:

_____

_____

Have you had a bad reaction to an insect bite? ❑ Yes ❑ No.

If yes, what insect? _____

Modifying Factors: Check any item below that makes you worse:

- ❑ Dust
- ❑ Exertion
- ❑ Raking Leaves
- ❑ Cleaning House
- ❑ Smoke
- ❑ Animals
- ❑ Mowing the Grass
- ❑ Weather Changes
- ❑ Odors
- ❑ Foods
- ❑ Exercise
- ❑ Change of Season
- ❑ Anger
- ❑ Infection
- ❑ Vacuuming
- ❑ Air Conditioning

Social History:

Do you drink alcohol? ❑ Yes ❑ No ❑ Beer ❑ Wine ❑ Liquor ___ per week

Do you smoke cigarettes? ❑ Yes ❑ No # ____ packs per day #_____ years of use

Do you use other forms of tobacco? ❑ Yes ❑ No ❑ Cigar ❑ Chew ❑ E-Cigarette

Marijuana/recreational drug use? ❑ Yes ❑ No

Immunizations:

Influenza vaccine	❑ Yes	❑ No	Date: _____
Pneumococcal conjugate vaccine (PCV13)	❑ Yes	❑ No	Date: _____
Pneumococcal polysaccharide vaccine (PPSV23)	❑ Yes	❑ No	Date: _____
Shingles vaccine (Zostavax)	❑ Yes	❑ No	Date: _____
Shingles vaccine (Shingrix)	❑ Yes	❑ No	Date: _____

Environment:

Which state did you previously live? _____

How long have you lived in Florida? _____

How old is your home? _____

Air Conditioning: ❑ Central ❑ Window ❑ Unit ❑ None

Current or recent pets? ❑ Yes ❑ No What type(s)? _____

Which rooms have carpeting? ❑ Living Room ❑ Bedroom ❑ Other ❑ None

Does your home have any mold growth, musty smell, past floods, or water leaks? ❑ Yes ❑ No

Does anyone smoke in the house or car? ❑ Yes ❑ No

Have you been exposed to chemicals at work or in the service? ❑ Yes ❑ No