



2793 Brownwood Boulevard
The Villages, Florida 32163
Phone: (352) 259-0151
Fax: (352) 259-0413
www.ASAFHC.com

309 La Grande Boulevard
The Villages, Florida 32159
Phone: (352) 750-1999
Fax: (352) 750-1998
www.ASAFHC.com

Edgar Rojas,
MD Consulting Physician

Francis E. Neuzil, Jr., Ph.D., APRN-BC
Board Certified Adult Medicine

Jenna Richardson, MSN, APRN, FNP-C
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

Gastrointestinal:

- Gastric Reflux
- Ulcers
- Inflammatory Bowel Disease
- Lactose Intolerance
- Celiac Disease

Autoimmune:

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

Cardiovascular:

- Heart Disease
- High Blood Pressure
- High Cholesterol
- Atrial Fibrillation
- Blood Clots

ENT:

- Glaucoma
- Cataracts
- Septal Deviation
- Nasal Polyps
- TMJ

Other:

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

Renal/GU:

- BPH (enlarged prostate)
- Kidney Disease
Stage _____

Neuro:

- Dementia
- Migraine
- Seizure
- Stroke
- Depression
- Anxiety

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

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:

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Dust | <input type="checkbox"/> Smoke | <input type="checkbox"/> Odors | <input type="checkbox"/> Anger |
| <input type="checkbox"/> Exertion | <input type="checkbox"/> Animals | <input type="checkbox"/> Foods | <input type="checkbox"/> Infection |
| <input type="checkbox"/> Raking Leaves | <input type="checkbox"/> Mowing the Grass | <input type="checkbox"/> Exercise | <input type="checkbox"/> Vacuuming |
| <input type="checkbox"/> Cleaning House | <input type="checkbox"/> Weather Changes | <input type="checkbox"/> Change of Season | <input type="checkbox"/> 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

Finally... How Did You Hear About Us? (Please check all that apply)

- Friend/Other Patient
- Other Physician _____
- Newspaper Ad
- Web Search
- Social Media/Facebook
- Radio Ad
- TV/Video
- Other _____