MEDICAL HISTORY FORM

Today's date: _____

Name: _____ Gender: ☐ Male ☐ Female

Address: _____

Race: ☐ White ☐ Black ☐ Other ☐ Asian ☐ Hispanic ☐ North American Native

Insurance Name: _____ Insurance Card #: _____

Home Phone #: _____ Cell Phone #: _____

DOB: _____ e-mail Address: _____

Preferred method to contact: ☐ text ☐ call ☐ e-mail

What medical problems do you have? (Example: Diabetes, Hypertension, Congestive Heart Failure, Chronic Low Back Pain, Arthritis of the Right Knee, Cancer of the Breast). Please indicate **all** problems below:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

What surgery have you had? What date was it done? (Example: Gallbladder removed by laparoscopy, Feb. 2004; Coronary artery bypass graft – 5 vessels, Summer 2006; Splenectomy, vaginal hysterectomy and both ovaries removed, 5/1/02; Abdominal hysterectomy and the right ovary removed, 1970).

SURGERY	DATE
1.	
2.	
3.	
4.	
5.	
6.	
7.	

Have you ever been admitted to the hospital? ☐ Yes ☐ No | If yes, where, date & reason:

WHERE	DATE	REASON
1.		
2.		
3.		
4.		
5.		
6.		

Please mail or return your completed form PRIOR to your scheduled appointment.

Mail: FHCP-Medical Records, 1340 Ridgewood Ave., Holly Hill, FL 32117

Fax: 386-481-5009 or 888-427-4544 **Scan and email:** medrecroi@fhcp.com

Florida Health Care Plans
An Independent Licensee of the Blue Cross and Blue Shield Association

Name: _____

What medications do you take? Include all over-the-counter medications. (Example: Atorvastatin 40 mg once a day, Lisinopril 20 mg once a day, Aspirin 81 mg once a day, Vitamin C 500 mg twice a day)			
MED	**DOSE**	**HOW OFTEN**	**WHO PRESCRIBED**
1. Example: Atorvastatin	40 mg	once a day	Dr. Smith
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			

What allergies do you have? What happens? (Example: Penicillin – shortness of breath, Sulfa–rash, Latex, rash).	
ALLERGIES	**REACTION**
1.	
2.	
3.	
4.	
5.	

List all the Physicians you see. (Example: Dr. Wesley Driggers - Family Medicine, Dr. Stephen Minor - Cardiology, Dr. Pamela Carbiener – OB/GYN).
1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

Please tell us about specific family members: ☐ Adopted – Family History Unknown

This will help us evaluate your future risk factors. Important diseases to include are Hypertension, Diabetes, Heart Disease, Kidney Disease, Types of Cancer, Bleeding Problems, Endocrine Problems, Neurologic Disease, Mental Health Diseases or Rheumatology Diseases like Lupus or Rheumatoid Arthritis.

Father: ☐ Living ☐ Deceased DOB: _____ or Age at death: _____

Medical problems: _____

Cause of death: _____

(Examples: Hypertension, Diabetes, cancer of the breast, cancer of the colon).

Please mail or return your completed form PRIOR to your scheduled appointment.

Mail: FHCP-Medical Records, 1340 Ridgewood Ave., Holly Hill, FL 32117

Fax: 386-481-5009 or 888-427-4544 **Scan and email:** medrecroi@fhcp.com

Florida Health Care Plans
An Independent Licensee of the Blue Cross and Blue Shield Association

Name: _____

Mother: ☐ Living ☐ Deceased DOB: _____ or Age at death: _____
Medical problems: _____
Cause of death: _____

Paternal Grandfather: ☐ Living ☐ Deceased DOB: _____ or Age at death: _____
Medical problems: _____
Cause of death: _____

Paternal Grandmother: ☐ Living ☐ Deceased DOB: _____ or Age at death: _____
Medical problems: _____
Cause of death: _____

Maternal Grandfather: ☐ Living ☐ Deceased DOB: _____ or Age at death: _____
Medical problems: _____
Cause of death: _____

Maternal Grandmother: ☐ Living ☐ Deceased DOB: _____ or Age at death: _____
Medical problems: _____
Cause of death: _____

Brother #1: ☐ Living ☐ Deceased DOB: _____ or Age at death: _____
Medical problems: _____
Cause of death: _____

Brother #2: ☐ Living ☐ Deceased DOB: _____ or Age at death: _____
Medical problems: _____
Cause of death: _____

Sister #1: ☐ Living ☐ Deceased DOB: _____ or Age at death: _____
Medical problems: _____
Cause of death: _____

Sister #2: ☐ Living ☐ Deceased DOB: _____ or Age at death: _____
Medical problems: _____
Cause of death: _____

Children Medical problems:

_____

_____

Please tell us about yourself.

Current occupation: _____

☐ Retired ☐ Disabled ☐ Student ☐ Never worked

Marital status:
- ☐ Currently married
- ☐ Divorced
- ☐ Separated
- ☐ Single
- ☐ Widowed

Please mail or return your completed form PRIOR to your scheduled appointment.
Mail: FHCP-Medical Records, 1340 Ridgewood Ave., Holly Hill, FL 32117
Fax: 386-481-5009 or 888-427-4544 **Scan and email:** medrecroi@fhcp.com

Florida Health Care Plans
An Independent Licensee of the Blue Cross and Blue Shield Association

Name: _____

EDUCATION

Highest level of education achieved: _____

☐ Currently in school Grade _____

☐ Doing well in school ☐ Having difficulty in school

☐ Not able to read ☐ Not able to write

TOBACCO

☐ Never smoked

Have you smoked at least 1 cigarette in the last 6 months? ☐ Yes ☐ No

Smoked _____ packs for _____ years

Quit smoking on _____
(Date)

ALCOHOL

☐ No alcohol in the last 12 months

☐ Recovering alcoholic

Drink _____ beers per week.

Drink _____ glasses of wine per week.

Drink _____ shots of liquor per week.

Have you ever felt you should cut down on your drinking? ☐ Yes ☐ No

Have people annoyed you by criticizing your drinking? ☐ Yes ☐ No

Have you felt guilty about your drinking? ☐ Yes ☐ No

Have you ever had a drink in the morning to steady your nerves or get rid of a hangover? ☐ Yes ☐ No

Have you had an accident or broken a bone due to drinking? ☐ Yes ☐ No

OTHER SUBSTANCES

☐ Use marijuana How often _____

☐ Use cocaine How often _____

☐ Use of street drugs – what _____ How often _____

Have you ever had a blood transfusion? ☐ Yes ☐ No

If yes, date of transfusion: _____

DIET

Do you eat at least 5 fruits or vegetables a day? ☐ Yes ☐ No

EXERCISE

What exercise do you do?

(Example: Walk 1 mile 3 days/week, water aerobics 1 hour once wk, go to gym & lift weights 30 mins 3x/wk)

1. _____
2. _____
3. _____
4. _____

Please mail or return your completed form PRIOR to your scheduled appointment.

Mail: FHCP-Medical Records, 1340 Ridgewood Ave., Holly Hill, FL 32117

Fax: 386-481-5009 or 888-427-4544 **Scan and email:** medrecroi@fhcp.com

Florida Health Care Plans
An Independent Licensee of the Blue Cross and Blue Shield Association

Name: _____

Do you have a caregiver? ☐ Yes ☐ No
If so, who is your caregiver: Name: _____
Phone: _____ Cell: _____
e-mail: _____
Caregiver on site: _____ days/week
Caregiver on site: _____ hours/day

What is your native language? _____
What other languages do you speak? _____

LIVING ARRANGEMENTS

☐ Private residence
☐ Apartment
☐ Assisted Living
☐ Nursing Home
☐ Hospice

Number of people living with you _____

Do you drive? ☐ Yes ☐ No
Do you use a ☐ Cane ☐ Walker ☐ Wheelchair

Do you have an Advance Directive? ☐ Yes ☐ No
Would you like more information on Advance Directives? ☐ Yes ☐ No
Who is your Power of Attorney? _____

PREVENTIVE

Have you had a colonoscopy? ☐ Yes ☐ No
If yes, where? _____ Date: _____

Have you had a Bone Density? ☐ Yes ☐ No Date: _____

Did you have chicken pox disease? ☐ Yes ☐ No Date: _____

Have you had a Pneumonia shot? ☐ Yes ☐ No Date: _____

Have you had a Tetanus shot? ☐ Yes ☐ No Date: _____

Have you had a Shingles shot? ☐ Yes ☐ No Date: _____

FEMALES:

Date of Last Pap Smear: _____
Have you ever had an abnormal pap? ☐ Yes ☐ No
Date of Last Mammogram: _____
Birth Control? _____

Please mail or return your completed form PRIOR to your scheduled appointment.
Mail: FHCP-Medical Records, 1340 Ridgewood Ave., Holly Hill, FL 32117
Fax: 386-481-5009 or 888-427-4544 **Scan and email:** medrecroi@fhcp.com