ADULT Patient History Form

Flagel Pediatric & Family Medicine

2560 Commerce Parkway

North Port, Florida 34289

David A. Flagel, M.D.

Board Certified, Family Medicine

Susan D. Flagel, D.O.

Board Certified, Pediatrics

Patient's Name: _____ Age: ____ Gender: ____ Date: _____

List primary reason for coming to the Doctor:

_____

_____

ALLERGIES: _____

List All Of Your Medications (including dosage, frequency) – if multiple, please provide list:

1) _____ **PHARMACY (Name, Cross Street, City)**
2) _____ _____
3) _____ _____
4) _____ _____
5) _____ _____

Patient/Family History: Please place a check if you or your family have ever had problems with any of the following:

	Patient	Family		Patient	Family		Patient	Family
Anemia:	____	____	ADHD/ADD:	____	____	Autism :	____	____
Bleeding problems:	____	____	Birth Defects	____	____	Cancer:	____	____
Cerebral Palsy:	____	____	Diabetes:	____	____	Down Syndrome:	____	____
Genetic disease:	____	____	Headaches	____	____	Heart problems:	____	____
Hearing Loss:	____	____	High Blood Pressure:	____	____	High Cholesterol:	____	____
Infertility:	____	____	Kidney problems:	____	____	Liver Function:	____	____
Lung problems:	____	____	Psychiatric:	____	____	Seizures:	____	____
Substance Abuse:	____	____	Thyroid:	____	____	Tuberculosis:	____	____
Urinary tract:	____	____	Other:	____	____			

Please explain any items that you have checked:

_____

_____

Adult Patient History Form

Females: Past Gynecological History: Last Menstrual Period: _____ # of Pregnancies: _____ Live Births: _____

Past Surgical History

Type of Surgery	Date	Type of Surgery	Date
_____		_____	
_____		_____	
_____		_____	

Social History:

Single: ____ Married: ____ Long Term Relationship: ____ Divorced: ____ Widowed: ____

Do you use Tobacco? Y____ N ____ If yes, How much/often? _____

Did you ever use Tobacco? Y____ N____ If yes, what age did you start? _____ What age did you quit? _____

How often do you drink Alcohol? Rarely _____ Occasionally _____ Weekends _____ Every Day _____

Family Status: ***Describe disease or cause of death if deceased:***

FATHER: Age ____ Living: ____ Deceased: ____ _____

MOTHER: Age ____ Living: ____ Deceased: ____ _____

BROTHER: Age ____ Living: ____ Deceased: ____ _____

BROTHER: Age ____ Living: ____ Deceased: ____ _____

SISTER: Age ____ Living: ____ Deceased: ____ _____

SISTER: Age ____ Living: ____ Deceased: ____ _____

OTHER (List): _____

_____

_____

Immunizations: Last Tetanus Booster? _____ Pneumonia Vaccine? _____ Flu Shot? _____

Zoster? _____ Gardisil? _____ Other? _____

If Patient is a child, are immunizations up to date? _____

Adult Patient History Form

REVIEW OF SYSTEMS

Do you have problems with any of the following?

Please Circle Your Answer

General: Change in weight Fever Night Sweats Fatigue Insomnia

Skin: Lumps/Nodules Breast Lumps Rashes Sores Dry Skin Abnormal lesions/Moles

Eyes: Glaucoma Blurred Vision Cataracts Itchy Eyes Wears Glasses/Contacts

Ears, Nose, Throat: Trouble Swallowing Sore Throat Snoring Nose bleeds Dentures
Sneezing Hoarseness Sinus Problems Buzzing in Ears Plugged Ears
Hearing Loss Earaches

Heme/Lymph: Swollen glands or lymph nodes Bleeding Anemia Excessive Bruising

Cardiovascular: Chest Pain Angina Irregular Heart Beat Heart Failure Valve problems
Murmurs Pain in legs with exertion Phlebitis Leg swelling Blood Clots
High Blood Pressure Other heart/Blood Vessel Problems

Respiratory: Shortness of Breath Difficulty Breathing Wheezing Coughing Asthma
Other Respiratory/pulmonary problems

Gastrointestinal: Abdominal Pain Nausea Vomiting Diarrhea Constipation Blood in Stool
Gall Bladder problems Dark Tarry Stools Intestinal bleeding Hemorrhoids
Ulcers Poor Appetite Hiatal Hernia

Genitourinary: Pain or Burning with urination Difficulty urinating Blood in Urine Kidney Stones
Slow or small stream difficulty starting urination getting up late at night often to urinate
Urgency to urinate poor bladder emptying Recurrent urinary infections
Sexual problems Abnormal vaginal bleeding/discharge Menstrual Problems

Neurological: Headaches Migraines Dizziness Loss of consciousness Stroke Seizure
Paralysis Numbness Weakness Faintness Tremors Confusion
Memory changes/forgetfulness dementia
Other Neurological Problems:

REVIEW OF SYSTEMS – continued

Psychiatric: Depression Suicidal Thoughts Anxiety Stress Bipolar Disorder Attention Deficit

Other Psychiatric Problems:

Musculoskeletal: Muscle pain Joint Pain Broken bones Gout Arthritis Joint replacement

Endocrine/Metabolic: Intolerance to heat or cold Hot flashes Flushing Excessive thirst

Unexplained weight loss Unexplained weight gain Excessive hunger

Changes with hair (brittle) Skin pigment changes

Do you have any other problems that you would like to discuss with your doctor?

_____

_____

_____

_____