ProHealth Family Physicians

3100 17th Street, St Cloud, FL, 34769 Phone (407)892-0009 Fax (407)892-3285

New Patient Medical History - Please complete this two-sided form prior to your first appointment

Name: _____ Date of Birth: ___/___/ _____ Age: ____ Sex: ____

How did you hear about our practice?

♦ Please briefly state in the box below the reason for your visit ♦

♦ Past Medical History ♦

Condition / Disease	*Year Began*	*Condition / Disease*	*Year Began*
❑ Hypertension		Other(s):	
❑ High Cholesterol			
❑ Hypothyroidism (low thyroid)			
❑ COPD, Emphysema or Asthma			
❑ Diabetes			
❑ GERD			
❑ Depression or Anxiety			
❑ Heart Problems -			
❑ Cancer-			
❑ Seizures-			

♦ Past Surgical Procedures / Hospitalizations / Serious Injuries or Fractures ♦

Operation / Hospitalization / Injury	*Month / Yr*	*Operation / Hospitalization / Injury*	*Month / Yr*

♦ Other Physicians and Specialists Seen by Patient ♦

List below your other physicians (i.e., Gyn, Dermatology, GI, Orthopedics, Urology, Psychiatry, etc)

♦ Medication or Food Allergies or Intolerances ♦

List below medications or foods causing an allergic reaction (i.e., rash, swelling) or intolerance (i.e., nausea)

Medication / Food	*Reaction*	*Medication / Food*	*Reaction*

♦ Medications, Vitamins and Herbal Supplements ♦					
Medication	***Strength***	***Number of pills taken & frequency***	***Medication***	***Strength***	***Number of pills taken & frequency***
Example: *Tylenol*	*500 mg*	*1 - twice daily*			

♦ Social, Educational and Work History ♦		
Marital Status:	Year of birth of children, if any:	
Work Status (circle one): Employed Unemployed / Retired / Disabled	Current or Prior Occupation:	Hours worked per week:
Highest Level of Education:	Completed at which institution / school:	
What type of exercises do you perform, duration & frequency?		
In what type of residence do you live (i.e., house, assisted living, nursing home)?		
What are your hobbies?		
Do you drink alcohol?	What type of alcohol?	No. of drinks per week?
Are you a current smoker?	If you smoke, how many packs per day?	
Are you a former smoker?	If so, what year did you quit?	No. of years you smoked?
On average, how much did you smoke per day?		
Are you sexually active: Yes / No	Do you have sex with: Men / Women / Both	How many partners have you had during the past 12 months?
Are you concerned that you may have been exposed to HIV? Yes / No		

♦ Family Health History ♦

Please list below the health history of your blood (genetic) first degree relatives

Relative	***Living or Deceased***	***Current age or age at death***	***Cause of Death***	***Health Problems***
Father:				
Mother:				
Brother(s):				
Sister(s):				

♦ Disease Prevention and Health Maintenance ♦

Please list below the most recent dates of your vaccines and health screening tests

	Month/Yr		***Month/Yr***		***Month/Yr***
Flu Vaccine		Mammogram		Eye Exam	

Pneumonia Vaccine		Pap Smear		Heart Catheterization	
Tetanus Vaccine		Colonoscopy		Endoscopy (EGD)	
Hepatitis B Vaccine		Bone Density		Heart Stress Test	
Shingles Vaccine		EKG		Ab Aneurysm Screen	
Gardasil Vaccine		Chest X-Ray		HIV Test	