South Naples
311 9th Street North, Suite 308
Naples, Florida 34102
(239) 417-0085

NCH Physician Group

North Naples
1280 Creekside Street, Ste 101
Naples, Florida 34108
(239) 624-0390

Patient Health History

Patient Name: _____ **Birth date:** _____

Today's Date _____

Birthplace _____

Highest level in school _____

Occupation _____

Prior occupations _____

Marital status _____

Hobbies _____

Habits: Do you currently smoke No Yes type & amount:

_____

Did you ever smoke? No Yes : When Quit?_____

Alcohol (type & amount)_____

Street drugs (type & amount)_____

Usual weight _____

Please list all allergies: _____

_____

_____

Name of primary doctor _____

Name of referring doctor _____

Please list any prior illnesses requiring hospitalizations and the year they occurred: _____

_____

_____

_____

Please list any prior surgery you have had and the year they occurred: _____

_____

_____

_____

Please list any medications you are presently taking and their dosages:_____

_____

_____

_____

_____

What is the nature of your concern(s) for today's visit? _____

Is this related to a work or auto accident? _____

Whom should we contact in case of emergency?_____

Phone #: _____ Cell Phone #: _____

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Patient Past and Family Health History

Patient Name: _____ **Birth date:** _____

Past Medical History

Have you had any of the following? (Circle yes or no)

Pneumonia.....	no	yes	Hepatitis.....	no	yes	Diabetes.....	no	yes
Rheumatic fever.....	no	yes	Stomach ulcers.....	no	yes	Cancer.....	no	yes
Heart disease.....	no	yes	Blood clots.....	no	yes	Glaucoma.....	no	yes
Arthritis.....	no	yes	Leg ulcers.....	no	yes	Hernia.....	no	yes
Anemia.....	no	yes	Kidney disease.....	no	yes	Blood transfusion.....	no	yes
Bladder infections.....	no	yes	Thyroid problems.....	no	yes	Hemorrhoids.....	no	yes
Seizures.....	no	yes	Bleeding problem.....	no	yes	Asthma.....	no	yes
Migraine headaches.....	no	yes	Back pain.....	no	yes	HIV/AIDS.....	no	yes
Tuberculosis.....	no	yes	High blood pressure.....	no	yes	Bronchitis.....	no	yes
Mitral valve prolapse.....	no	yes	Stroke.....	no	yes	Anesthesia problem....	no	yes

Family History

Have family had any of the following? (Circle yes or no)

Breast Cancer.....	no	yes	Mental illness.....	no	yes	Diabetes.....	no	yes
Colon Cancer.....	no	yes	Lymphoma/Leukemia..	no	yes	Cancer (other).....	no	yes
Heart disease.....	no	yes	Blood clots.....	no	yes	Seizures.....	no	yes
Hypertension.....	no	yes	Kidney disease.....	no	yes	Anesthesia problem....	no	yes
Anemia.....	no	yes	Thyroid problems.....	no	yes			
Stroke.....	no	yes	Bleeding problem.....	no	yes			

Active medical problems

Do you presently experience any: (Circle yes or no)

Tiredness/Weakness.....	no	yes	Eye problems.....	no	yes	Blood in stools.....	no	yes
Weight loss.....	no	yes	Sore throat/hoarseness	no	yes	Heartburn.....	no	yes
Poor appetite.....	no	yes	Breast lump/drainage..	no	yes	Nausea and vomiting....	no	yes
Fever/chills.....	no	yes	Shortness of breath.....	no	yes	Diarrhea.....	no	yes
Night sweats.....	no	yes	Chest pain.....	no	yes	Constipation.....	no	yes
Skin problems.....	no	yes	Palpitations.....	no	yes	Bladder infections.....	no	yes
Vision changes.....	no	yes	Hands/feet swelling.....	no	yes	Brown urine.....	no	yes
Migraine headaches.....	no	yes	Leg pain/cramps.....	no	yes	Blood in urine.....	no	yes
Ear pain/drainage.....	no	yes	Varicose veins.....	no	yes	Difficulty urinating.....	no	yes
Bruising/bleeding.....	no	yes	Abdominal pain.....	no	yes			

To the best of my knowledge, the questions above have been answered accurately. I understand providing false information may be endangering my health.

_____ _____

Patient Signature **Today's Date**