

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



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 _____

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 #: _____

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: _____

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



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

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