FLORIDA HEART & LUNG INSTITUTE

NORTH FLORIDA REGIONAL HEALTHCARE

Name: ______________________ Today's Date ____________

DOB ______________________ Who Referred you to our office? ______________________

Please list why are you being seen by a our providers today:
(Please include how long you have had this problem)

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Please list your current medication: ☐ **I have a written list of my medication.**

**** Please include all Vitamins, Supplements and Herbs you take as well**

Medication	Strength	How Often

Please list all major medical conditions you have or have experienced in the past.

Condition	Date (Month / Year)

Please list any know Allergies ☐ **I have no known allergies**

Allergy	Type of Reaction

Please list all previous surgeries with approximate dates

Surgery	Date (Month / Year)

Family History: **Are you adopted?** **Yes** **No**

Family Member	**Status** **A-Alive** **D-** **Deceased**	**Year of Birth**	**Age (Years)**	**Known Medical Condition or cause of death**
MOTHER	A D U			
FATHER	A D U			
BROTHER	A D U			
BROTHER 2	A D U			
BROTHER 3	A D U			
SISTER	A D U			
SISTER 2	A D U			
SISTER 3	A D U			
DAUGHTER	A D U			
DAUGHTER 2	A D U			
DAUGHTER 3	A D U			
SON	A D U			
SON 2	A D U			
SON 3	A D U			
MATERNAL GRANDMOTHER	A D U			
MATERNAL GRANDFATHER	A D U			
PATERNAL GRANDMOTHER	A D U			
PATERNAL GRANDFATHER	A D U			

Social History: Do you use tobacco products? Y / N Former Y / N

If Yes, what type, how often? ______________________________

Alcohol Use: _____ Heavily ____ Moderately _____ Socially
_____ Occasionally _____ Rarely _____ Never

Please circle yes or no if you are currently experiencing any of the following items

Review of Systems					
Fever	Y / N	Shortness of Breath	Y / N	Frequent Urination	Y / N
Chills	Y / N	Asthma	Y / N	Difficulty Urinating	Y / N
Weight Loss	Y / N	Nausea	Y / N	Breast Pain	Y / N
Tiredness	Y / N	Belly Pain	Y / N	Breast Lumps	Y / N
Hard of Hearing	Y / N	Hernias	Y / N	Nipple Discharge	Y / N
Poor Eyesight	Y / N	Change in bowel habits	Y / N	Prostate Problems	Y / N
Blurry Vision	Y / N	Constipation	Y / N	Trouble Swallowing	Y / N
Chest Pain	Y / N	Hemorrhoids	Y / N	Dizziness	Y / N
Bleeding Problems	Y / N	Diarrhea / Irritable Bowel	Y / N	Fainting	Y / N
Poor Circulation	Y / N	Rectal Pain	Y / N	Pain with Eating	Y / N
Unable to Lie Flat	Y / N	Vomiting	Y / N	Scrotal Mass	Y / N
Ankle swelling	Y / N	Pain with Walking	Y / N	Irregular Periods	Y / N
Irregular Heartbeat	Y / N	Urine leakage	Y / N	Vaginal Discharge	Y / N
Cough	Y / N	Blood in Urine	Y / N	Are you Breast Feeding	Y / N