ORLANDO OFFICE
724 Charles Street,
Orlando, FL 32808

Orlando & St. Cloud Family Medicine

ST. CLOUD OFFICE
3107 13th Street, St. Cloud, FL 34769

http://www.siddiquifamilymed.com
Orlando Phone: 407.295.5625 / St. Cloud Phone: 407.957.7700
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MEDICAL HISTORY FORM

DEMOGRAPHICS

NAME (LAST, FIRST, MIDDLE)	DATE OF BIRTH / / MM DD YYYY

PAST MEDICAL HISTORY / CURRENT DIAGNOSED CONDITIONS *(Mark an "X" on conditions that apply to you.)*

- ☐ Anemia
- ☐ Aneurysm
- ☐ Arthritis
- ☐ Birth defects
- ☐ Bleeding Disorder
- ☐ Cancer (Please indicate type): _____
- ☐ Diabetes (Please indicate type): _____
- ☐ Epilepsy/Neurological
- ☐ Eye problems
- ☐ Frequent headaches
- ☐ Glaucoma
- ☐ Hearing loss
- ☐ Heart disease
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ HIV/AIDS
- ☐ Kidney/Bladder Disease
- ☐ Liver disease/Hepatitis
- ☐ Lung/Respiratory disease
- ☐ Mental health (Please indicate type): _____ _____
- ☐ Osteoporosis
- ☐ Rheumatic fever
- ☐ Stomach/Gastric disease
- ☐ Stroke/CVA brain
- ☐ Thyroid Disease

☐ Others (Please list): _____
_____

FAMILY HISTORY *(Please indicate which conditions each member has.)*

	Alive	Deceased	Diabetes	Hypertension	Heart Disease	Mental Illness	Cancer	Unknown	Other (Please indicate below)
Father	☐	☐	☐	☐	☐	☐	☐	☐	☐
Mother	☐	☐	☐	☐	☐	☐	☐	☐	☐
Brother(s) - *# of brothers:*	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sister(s) - *# of sisters:*	☐	☐	☐	☐	☐	☐	☐	☐	☐
Daughter(s) - *# of daughters:*	☐	☐	☐	☐	☐	☐	☐	☐	☐
Son(s) - *# of sons:*	☐	☐	☐	☐	☐	☐	☐	☐	☐
Paternal Grand Father	☐	☐	☐	☐	☐	☐	☐	☐	☐
Paternal Grand Mother	☐	☐	☐	☐	☐	☐	☐	☐	☐
Maternal Grand Father	☐	☐	☐	☐	☐	☐	☐	☐	☐
Maternal Grand Mother	☐	☐	☐	☐	☐	☐	☐	☐	☐

Please list any FAMILY HISTORY that was not listed above: _____
_____

HISTORY OF HOSPITALIZATIONS / SURGERIES *(Please indicate date, hospital or urgent care and reason for visit including ER / type of surgery.)*

Date (Month / Year)	Name of hospital or urgent care center & reason for visit / Type of Surgery

ALLERGIES & MEDICATION SIDE EFFECTS *(Please indicate agent/substance/medication and reaction or side effect.)*

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OB-GYN HISTORY (FEMALE ONLY)		
Last menstrual period:	Last pap smear date: Result:	Last mammogram date: Result:
Total pregnancies (please include stillbirths, miscarriages, & abortions):	Total living children:	Number of full-term delivery:

SOCIAL HISTORY		
Travel outside of the United States in the last six months: YES / NO	Pets at home: YES / NO	Exercise: YES / NO Type: How often:

TOBACCO HISTORY				
Tobacco usage: ☐ Current ☐ Former ☐ Never	Type: ☐ Cigarettes ☐ Cigars ☐ Other (please indicate): _____	Amount per day:	Years Used: Year Quit:	Ever tried to quit? Which method:

ALCOHOL HISTORY			
Alcohol usage: ☐ Yes ☐ Former ☐ No	Type:	Amount & Frequency:	Year quit:

CAFFEINE		
Caffeine use: ☐ Yes ☐ No	Type ☐ Coffee ☐ Energy drinks ☐ Tea ☐ Other (please indicate): ☐ Soda _____	Cups per day: ☐ None ☐ 3-4 cups per day ☐ 1-2 cups per day ☐ More than 4 cups per day ☐ 2-3 cups per day

DRUG HISTORY			
Drug usage: ☐ Yes ☐ Former ☐ No	Type:	Number of years used:	Year quit:

HEALTH MAINTENANCE *(Please indicate the dates [MONTH/YEAR], if applicable)*					
Last Complete Physical Exam	Last Cholesterol Blood Test	Last EKG	Last Stool Test for Blood	Last Chest X-Ray	
Last Eye Exam	Last Foot Exam	Last DEXA (Bone Density Exam)	Last Colonoscopy	**MEN:** Last Prostate Exam	
Last Flu Shot	Last Pneumonia Vaccine	Last TDAP Vaccine	Last Shingles Vaccine	Last HPV Vaccine	Last Hep B Vaccine

MEDICATIONS *(Please list all current medication that you are taking including supplements and over-the-counter medications)*			
Medication Name	**What is the medication for?**	**Dosage**	**Times Daily**
Example: Tylenol	Fever	500 mg	Once daily
Please list additional medications on a separate sheet.			