2019

PRIMARY CARE PHYSICIANS of Gainesville

Springhill Professional Park, 3780 NW 83rd Street • Gainesville, Florida 32606
Phone: 352-377-2022 • Fax: 352-377-9113 • www.pcpgnv.com
Hours: Monday - Friday 8-5

Name:_____

SS#:_____ Birthday:_____ Age: _____ Sex: □ Male □ Female

Past Medical History:

- Are you in good health? □ Yes □ No
- Do you have a reason to limit your activity? □ Yes □ No
- Do you have a permanent disability as result of a disease or accident? □ Yes □ No
- Have you consulted or been treated by any health care providers within the past 5 years, excluding routine checkups? □ Yes □ No

If "yes" give reasons:_____

_____

_____

- Have you had any illness, injury or hospitalization not already noted? □ Yes □ No

If "yes" explain: _____

_____

_____

- Are taking any medications? □ Yes □ No

If "yes" list medications:

Name	Dose	Strength	Frequency

- Do have any chronic illness? □ Yes □ No

If "yes" what: _____

_____

_____

Past Surgical History:

Type of Surgery	Date	Reason

Allergies:

Please circle: Penicillin Sulfa Drugs Tetracycline Serum Aspirin X-ray Dye

- Are you allergic to any other medications?_____
- Are you allergic to any foods? _____

Immunizations:

	Yes	No	Date		Yes	No	Date
• MMR (measles, mumps, rubella)	☐	☐	_____	• Diphtheria/Tetanus	☐	☐	_____
• Pneumovax (pneumonia)	☐	☐	_____	Last booster			_____
• TB skin test	☐	☐	_____	• Flu Vaccine	☐	☐	_____

Social History:

	Yes	No	Type and Quantity
Smoking/tobacco use?	☐	☐	_____ # years of use:_____ If you've quit, when?_____
Caffeine consumption?	☐	☐	_____
Alcohol consumption?	☐	☐	_____
Vitamins?	☐	☐	_____
Herbs?	☐	☐	_____

Exercise? ☐ None ☐ Cardio ☐ Weights ☐ Stretching/Yoga How many days/hours per week?_____

Relationship status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed ☐ Separated ☐ Significant other

Education- Highest level completed:_____ Current occupation:_____

Family History (please specify relationship- example: maternal grandmother):

	Yes	No	Relationship		Yes	No	Relationship
Tuberculosis	☐	☐	_____	Obesity	☐	☐	_____
Diabetes	☐	☐	_____	High blood pressure	☐	☐	_____
Kidney disease	☐	☐	_____	Psychological problems	☐	☐	_____
Heart disease	☐	☐	_____	Osteoporosis	☐	☐	_____
Anemia	☐	☐	_____	Breast cancer	☐	☐	_____
Stomach disease	☐	☐	_____	Colon cancer	☐	☐	_____
Asthma/hay fever	☐	☐	_____	Thyroid problems	☐	☐	_____
Epilepsy/convulsions	☐	☐	_____	Other	☐	☐	_____

Please list the name(s) and relationship of the people who live in your home:

_____ _____ _____ _____ _____ _____

Review of Systems- check which of the following you have had within the past 6 months:

☐ Fever	☐ Nose bleeds	☐ High blood pressure	☐ Urinary frequency	☐ Increased thirst
☐ Weight change	☐ Nasal/sinus problems	☐ Heart murmur	☐ Painful urination	☐ Hot/cold intolerance
☐ Appetite change	☐ Nipple discharge	☐ Fainting	☐ Blood in urine	☐ Anemia
☐ Fatigue	☐ Breathlessness	☐ Leg swelling	☐ Vaginal discharge	☐ Easy bleeding
☐ Rash	☐ Wheezing	☐ Abdominal pain	☐ Penile discharge	☐ Seizure
☐ New skin lesions	☐ Cough	☐ Heartburn	☐ Trouble with erection	☐ Weakness
☐ Headache	☐ Tuberculosis	☐ Nausea/vomiting	☐ Pelvic pain	☐ Numbness
☐ Dizziness	☐ Coughing up blood	☐ Constipation	☐ Abnormal vaginal bleeding	☐ Decreased memory
☐ Visual changes	☐ Chest pain	☐ Diarrhea	☐ Joint pain/swelling	☐ Nervousness
☐ Tooth/gum problems	☐ Palpitations	☐ Blood in stool	☐ Neck pain	☐ Depression

Please Read- Official Financial Policy:

1. Credit will not be extended on initial visits to our office.
2. Credit for return visits will only be extended if the previous payment record is good.
3. Exceptions to the above policy may only be made in the cases of true medical emergencies with approval of the doctor.

Please sign below indicating you understand our policies

Signature of patient:_____ Date:_____

Medical Consent for Medical Treatment of Minors:

I hereby grant permission to Primary Care Physicians of Gainesville to render to my child any emergency treatment or surgical care that might be deemed necessary to the health and well-being of my child. Also, when necessary for executing such care, I grant permission for hospitalization at an accredited hospital.

Please sign below indicating you understand and consent to the statement above

Signature of biological parent: _____ Date:_____