**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 a result of a disease or accident? □ Yes □ No
  
  If "yes" give reasons: __________________________________________________________
  __________________________________________________________
  __________________________________________________________

- 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 you taking any medications? □ Yes □ No
  
  If "yes" list medications:

<table>
<thead>
<tr>
<th>Name</th>
<th>Dose</th>
<th>Strength</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

- Do you have any chronic illness? □ Yes □ No
  
  If "yes" what: ________________________________________________________________
  __________________________________________________________

**Past Surgical History:**

<table>
<thead>
<tr>
<th>Type of Surgery</th>
<th>Date</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

**Allergies:**

- Are you allergic to any other medications? ____________________________________________
- Are you allergic to any foods? ______________________________________________________

**Immunizations:**

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Date</th>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>MMR (measles, mumps, rubella)</td>
<td></td>
<td></td>
<td></td>
<td>Diphtheria/Tetanus</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Last booster</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumovax (pneumonia)</td>
<td></td>
<td></td>
<td></td>
<td>Flu Vaccine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TB skin test</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Social History:

<table>
<thead>
<tr>
<th>Smoking/tobacco use</th>
<th>Yes</th>
<th>No</th>
<th>Type and Quantity</th>
<th># years of use:</th>
<th>If you’ve quit, when:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caffeine consumption</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol consumption</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vitamins</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Herbs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exercise?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relationship status</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Education - Highest level completed: __________________________ Current occupation: __________________________

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

<table>
<thead>
<tr>
<th>Tuberculosis</th>
<th>Yes</th>
<th>No</th>
<th>Relationship</th>
<th>Obesity</th>
<th>Yes</th>
<th>No</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
<td></td>
<td>High blood pressure</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kidney disease</td>
<td></td>
<td></td>
<td></td>
<td>Psychological problems</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart disease</td>
<td></td>
<td></td>
<td></td>
<td>Osteoporosis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anemia</td>
<td></td>
<td></td>
<td></td>
<td>Breast cancer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stomach disease</td>
<td></td>
<td></td>
<td></td>
<td>Colon cancer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma/hay fever</td>
<td></td>
<td></td>
<td></td>
<td>Thyroid problems</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Epilepsy/convulsions</td>
<td></td>
<td></td>
<td></td>
<td>Other</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

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