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Patient Medical Data Base

Today's Date: ____

Name ____ SSN ____ Date of Birth ____

Address ____ Cell Phone ____ Home Phone ____

City ____ State ____ ZIP code ____ Work Phone ____ e-mail ____

How long have you lived in Florida? ____ Previous city and state ____

In case of emergency, notify: ____ Pharmacy ____

How did you find out about this office? ____ Pharmacy phone ____

Please list all medications that you currently take and how often you take them. Please include over-the-counter and herbal ones. ____

Allergies: List any allergies to medications and the type of reaction ____

Please list all hospitalizations - try to start with the most recent:

Year	Illness or Operation	Hospital

Have YOU ever had or been diagnosed with any of the following?

- ☐ Allergies (cats, dogs, pollen, etc. - not medications), hay fever
- ☐ Anemia (low red blood count), unusual bleeding or bruising
- ☐ Asthma, bronchitis, emphysema, COPD, pneumonia, pleurisy
- ☐ Diabetes (high glucose), thyroid disease/goiter
- ☐ Cancer or tumors
- ☐ Seizures, epilepsy, fits, convulsions
- ☐ Glaucoma, cataracts
- ☐ Heart trouble, heart murmur, irregular heart beat
- ☐ Stroke, paralysis, poor circulation of the arms or legs
- ☐ High blood pressure, varicose veins, phlebitis
- ☐ Kidney disease, kidney stones, bladder problems, urine infections
- ☐ Chronic skin problems, psoriasis, dandruff
- ☐ Arthritis, rheumatism, gout, rheumatic fever, or scarlet fever
- ☐ Colitis, spastic colon, chronic diarrhea, irritable bowel
- ☐ Gall bladder trouble, gallstones
- ☐ Heartburn, ulcers. stomach trouble
- ☐ Hemorrhoids (piles), colon polyps
- ☐ Yellow jaundice, cirrhosis, or Hepatitis A, B, or C
- ☐ Nervousness, depression, anxiety, emotional problems
- ☐ Tuberculosis
- ☐ Venereal disease (syphilis, herpes, gonorrhea, veneral warts
- ☐ Ever had a blood transfusion?
- ☐ TB test Last time? ____
- ☐ Tetanus shot Last time? ____
- ☐ Flu shot Last time? ____
- ☐ Pneumonia shot Last time? ____

List any other serious illnesses or injuries not listed above.... ____

Name:

Social history

Who do you live with? Relation

Do you have any pets? If yes, what kind?

Are you on a diet? If yes, what kind?

Do you participate in any regular exercise? If yes, what kind?

Are you regularly exposed to any toxic chemicals or fumes? If yes, what kind?

Are there smoke alarms/fire extinguishers in your home?

Do you wear your seat belt/motorcycle helmet every time?

Do you have a Living Will, Health Care Surrogate? Would you like to discuss it? Would you like more information about getting one?

Do you smoke? If yes, how much? If yes, about how many total years? Have you ever quit?

Do you drink alcohol? If yes, how many drinks per day? How many days per week/month/year do you have something to drink?

Were you ever a "heavy" drinker, or did it interefere with your job or family or social life? Is there any alcoholism in your family?

Have you ever used recreational drugs? (cocaine, crystal meth, heroin, etc.)? Have you ever injected drugs?

Have you ever used narcotics or addictive drugs? How long has it been since using any prescription or recreational drugs?

Have you ever felt that you needed to cut down on your alcohol or drug use? Have people annoyed you by criticizing your drinking or drug use?

Have you ever felt bad or guilty about your drinking or drug use?

Have you ever needed a drink or drugs the first thing in the morning to steady your nerves or get rid of a hangover?

Are you currnetly working? What is your occupation? (current or last) Employer

Are you currently on disability? If you are not working, when was the last date that you worked?

Do you have any other worries (legal, financial, personal) that might be affecting your health? Specify, if you wish:

Family history - Has any blood relatives had any of the following? If yes, who?

Diabetes/sugar		Nerve disease	
Cancer		Muscle disease	
Allergies/asthma		Stroke	
Heart disease/angina		Psoriasis	
High blood pressure		Tuberculosis	
High cholesterol		Arthritis	

Please list the age (or age at time of death) and general state of health for your family members:

Mother	age:			age:	
Father	age:			age:	
	age:			age:	
	age:			age:	
	age:			age:	
	age:			age:	
	age:			age:	
	age:			age:	

Any comments on health problems in the family?

Review of Systems

Name

Are you currently having any problems with the following?

General:

- Recent fevers
- Night sweats
- Undue tiredness or fatigue
- Weight gain or loss. How much?
- What is your "normal" weight?

Head and Neck:

- Tense or frequent headaches
- Fainting spells
- Hair change or loss
- Thyroid trouble or goiter
- Stiffness or pain, swollen glands

Eyes:

- Glasses or cantact lenses
- Discharge or pain
- Blurred vision or floaters/spots
- Glaucoma or cataracts

Nose:

- Drainage or bleeding
- Difficulty breathing
- Post nasal drip, hay fever, allergies

Mouth:

- Dentures, gum disease, tooth abscesses
- Sore throat, hoarseness
- Difficulty swallowing pills, solid food, or liquids

Ears

- Hearing loss or ringing in the ears
- Pain or discharge

Breasts:

- Lumps
- Discharge or pain
- Ever have a mammogram? Last time?

Skin:

- Rashes, lumps, itching, dandruff
- Easy bruising, slow healing
- Skin cancer - if yes, which type?

Extremities:

- Joint pain or swelling, varicose veins
- Paralysis or weakness
- Numbness, tingling, burning, or electric shocks
- Back pain, pain with walking

Respiratory:

- Cough
- Phlegm (sputum) or blood, pain on breathing
- Pneumonia, wheezing

Heart:

- Pain or pressure on exertion
- Shortness of breath on exertion or at rest
- Heart murmur, feeling heart skip or rapid beats
- Tightness in chest or jaw
- High blood pressure - if yes, about how long?
- Cannot sleep lying flat, or wake up feeling short of breath
- Swelling of ankles

Gastrointestinal:

- Loss of appetite
- Heartburn, indigestion, reflux
- Nausea, vomiting, vomiting blood
- Diarrhea, bloating, irritable bowels
- Constipation
- Blood in stool, hemorrhoids, stool black or white in color
- Abdominal pain
- Food intolerance - which foods?

Urinary:

- Pain, burning or blood with urination
- Going frequently, trouble starting urine, leakage
- Up at night to pass water - how many times?

Men:

- Prostate trouble, enlargement, infection
- Sores or discharge from the penis - lumps or infections in your testicles
- Trouble getting or keeping an erection

Women:

Age started menstruation: Date of last period:

- Painful or irregular periods, or spotting between periods
- Vaginal discharge, pain with intercourse
- Used birth control pills, now or in the past

Number of pregnancies: Births: C-sections:

Miscarriages: Abortions:

Psychological:

- Depression
- Excessive worry, panic attacks
- Trouble sleeping, snoring, sleep apnea

HIV patients only

Name:

Approximate date of first HIV + test:

Approximate date of last HIV negative test:

Most recent CD4 count: When?

Most recent Viral Load: When?

Lowest CD4 count ever: When?

Where were you living when diagnosed with HIV? City: County: State: ZIP:

Ethnicity/race:
- White/caucasian
- Black/African-American
- Native Hawaiian or other Pacific Islander
- Hispanic/Latino
- Multiracial
- Asian
- American Indian/Alaska Native

Country of Birth:

Have you ever taken any of the following medications?

- Retrovir - AZT - zidovudine
- Videx - ddI - didanosine
- Hivid - ddC - zalcitabine
- Epivir - 3TC - lamivudine
- Zerit - d4T - stavudine
- Ziagen - abacavir
- Emtriva - emtricitabine
- Combivir (Retrovir + Epivir)
- Trizivir (Retrovir + Epivir + Ziagen)
- Epzicom (Epivir + Ziagen)
- Viread - tenofovir
- Truvada (Viread + Emtriva)
- Atripla (Viread + Emtriva + Sustiva
- Viramune - nevirapine
- Sustiva - efavirenz
- Intelence - etravirine
- Rescriptor - delavirdine
- Isentress - raltegravir
- Selzentry - maraviroc
- Fuzeon - T-20 - enfuvirtide
- Crixivan - indinavir
- Viracept - nelfinavir
- Invirase - saquinavir
- Fortovase - saquinavir
- Agenerase - amprenavir
- Lexiva - fosamprenavir
- Norvir - ritonavir
- Kaletra - lopinavir/ritonavir
- Reyataz - atazanavir
- Aptivus - tipranavir
- Prezista - darunavir
- Any medication not listed - please specify:

Have you ever taken a medication that was so horrible that you never want to take it again? If Yes, please specify:

Between 1977 and the first positive HIV test, have you ever:

- Had sex with a male
- Had sex with a female
- Injected non-prescription drugs
- Received clotting factor for hemophilia/coagulation disorder

Specify disorder: Factor VIII (hemophilia A) Factor IX (hemophilia B) Other - specify

- Received transplant of tissue/organs or had artificial insemination
- Worked in a health-care or laboratory setting
- Received transfusion of blood/blood components (except clotting factor) If yes, what dates:

Had heterosexual relations with any of the following:

- Intravenous/injection drug user
- Bisexual male
- Person with hemophilia/coagulation disorder
- Transfusion recipient with HIV
- Person with HIV or AIDS, risk factor not known
- Transplant recipient with HIV

Thank - you!

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