SMC
SARASOTA MEDICAL CENTER

Medical History

Please fill out to the best of your ability and focus on what is pertinent to today.

Name:_____ Age:_____ Date of Birth:_____ Sex:_____ Date: _____

General Health Status:

Please rate your health: ___ Excellent ___ Good ___ Fair ___ Poor

Exercise: ___ Athlete ___ Heavy ___ Daily ___ Moderate ___ None

Health Habits: Smoking ___No ___ Yes, ___ packs/day ___Years Alcohol ___No ___Yes, ____ drinks per week

Family History:

Please list if your father, mother, sibling, grandparent, or aunt/ uncle has had any of the following conditions.

Arthritis :_____ Cancer:_____

Cholesterol: _____ Diabetes: _____

Heart Disease: _____ Hypertension: _____

Psychological: _____ Seizure/ Epilepsy:_____

Stroke: _____ Other: _____

Allergies: _____

Prescription Medications: _____

_____

_____

Non-Prescription Medications/ Vitamins/ Supplements/ Herbs: _____

_____

Previous Surgeries/ Hospitalizations: _____ Year: _____

_____ Year: _____

_____ Year: _____

_____ Year: _____

Cardiovascular:	**Yes**	**No**
Heart Attack	( )	( )
Chest Pain	( )	( )
Pacemaker/Defibrillator	( )	( )
Leg/Ankle Swelling	( )	( )
Palpitations	( )	( )
Irregular Pulse	( )	( )
Muscle pain/cramps	( )	( )
Heart Murmur/Arrhythmia	( )	( )
Abnormal EKG	( )	( )
High Blood Pressure	( )	( )
Eyes, Ears, Nose, Throat	**Yes**	**No**
Hearing Loss	( )	( )
Uncorrectable Vision Loss	( )	( )
Fever Blisters	( )	( )
Swallowing Difficulty	( )	( )
Blood/ Lymphatic	**Yes**	**No**
Bleeding Disorder	( )	( )
Anemia	( )	( )
Transfusions	( )	( )

Respiratory	**Yes**	**No**
Recent Infection	( )	( )
Asthma	( )	( )
Pneumonia	( )	( )
Tuberculosis	( )	( )
Chronic Cough	( )	( )
Shortness of Breath	( )	( )
COPD	( )	( )
CPAP Machine	( )	( )
Neurological	**Yes**	**No**
Stroke/ TA	( )	( )
Migraine	( )	( )
Black Out Spells	( )	( )
Dizziness	( )	( )
Weakness/Paralysis	( )	( )
Motion/Car Sickness	( )	( )
Endocrine	**Yes**	**No**
Diabetes	( )	( )
Thyroid Problems	( )	( )
Pituitary Problems	( )	( )

Gastrointestinal	**Yes**	**No**
Hepatitis	( )	( )
Jaundice	( )	( )
Ulcer	( )	( )
Hiatal Hernia	( )	( )
Pancreatitis	( )	( )
Vomiting Blood	( )	( )
Colitis	( )	( )
Blood in Stool	( )	( )
Hemorrhoids	( )	( )
Change in Bowels	( )	( )
Genitourinary	**Yes**	**No**
Bladder Infection	( )	( )
Kidney Infection	( )	( )
UTI	( )	( )
Stones in Urine	( )	( )
Blood in Urine	( )	( )
Incontinence	( )	( )
Blockage of Urine	( )	( )
Prostrate Problem	( )	( )

Musculoskeletal	**Yes**	**No**
Fractures	( )	( )
Dislocations	( )	( )
Joint Pains	( )	( )
Arthritis	( )	( )
Back Pain	( )	( )
Neck Stiffness	( )	( )
Neck Immobility	( )	( )

Last Menstral Period:

_____

Using Other Providers?

Cardiologist	( )	( )
Chiropractor	( )	( )
Dentist	( )	( )
Family Doctor	( )	( )
Gastroenterology	( )	( )
Neurologist	( )	( )
OB/GYN	( )	( )
Orthopedist	( )	( )
Rheumatologist	( )	( )