DATABASE

PLEASE COMPLETE ALL QUESTIONS **DATE:** _____

NAME: _____ **MARITAL STATUS:** ☐ S ☐ M ☐ W ☐ D
ADDRESS: _____ **PHONES:** H _____ W _____
OCCUPATION: _____ **DATE OF BIRTH:** _____

FAMILY HISTORY: **If any blood relative has suffered any of the following, please indicate which relative**

☐ Epilepsy	☐ Diabetes	☐ Arthritis	☐ Alcoholism	☐ Stroke
☐ Migraine	☐ Thyroid Disease	☐ Gout	☐ Asthma	☐ High Blood Pressure
☐ Mental Illness	☐ Bleed Easily	☐ Osteoporosis	☐ Heart Disease	☐ Anemia
☐ Kidney Disease	☐ Cancer	☐ Alzheimer's Disease	☐	☐

PERSONAL MEDICAL HISTORY **SURGERIES/YEAR**

☐ Appendectomy	_____	☐ Breast	_____	☐ Cataracts	_____	☐ Gall Bladder	_____
☐ Hernia	_____	☐ Hysterectomy	_____	☐ Tonsillectomy	_____	☐	_____

OTHER HOSPITALIZATONS AND PAST MEDICAL HISTORY

☐ **TETANUS** _____ ☐ **PNEUMO VAX** _____ ☐ **FLU VAX** _____

LIST ALL MEDICATIONS YOU ARE NOW TAKING	1	5	9	**DRUG ALLERGIES**			
	2	6	10				
	3	7	11				
	4	8	12				

CHIEF COMPLAINT(S) 1 2 3

HISTORY OF PRESENT ILLNESS:

MARK (C) FOR CURRENT PROBLEMS. CHECK & INDICATE AGE WHEN YOU HAD ANY OF THE FOLLOWING:

☐ Decreased Hearing	☐ Swollen Ankles	☐ Painful Urination	☐ Numbness/Tingling Sensations
☐ Ringing in Ear	☐ Fainting Spells	☐ Blood in Urine	☐ Dizziness
☐ Leg Pain When Walking	☐ Overnight Urination	☐ Headaches - Frequent	☐ Wear Glasses/Contacts
☐ Varicose Veins/Phlebitis	☐ More Than 2 Times	☐ Arthritis/Rheumatism	☐ Double or Blurred Vision
☐ Loss of Appetite-Recent	☐ Control in Urination	☐ Back Pain-Recurrent	☐ Eye Pain
☐ Difficulty Swallowing	☐ Decrease in Force of	☐ Bone Fracture	☐ Sinus Trouble
☐ Indigestion or Heartburn	Urination	☐ Joint Injury	☐ Sore Throats-Frequent
☐ Persistent Nausea	☐ Kidney stones	☐ Gout	☐ Hayfever/Allergies
☐ Persisting Vomiting	☐ Venereal Disease	☐ Foot Pain	☐ Hoarseness-Prolonged
☐ Peptic Ulcers	☐ Chronic Fatigue	☐ Rashes	☐ Pneumonia/Pleurisy
☐ Abdominal Pain-Chronic	☐ Weight Loss-Recent	☐ Hives	☐ Bronchitis/Chronic cough
☐ Change in Bowel Habits	☐ Anemia	☐ Psoriasis	☐ Asthma/Wheezing
☐ Diarrhea	☐ Bruise Easily	☐ Eczema	☐ Sleeping Difficulty
☐ Shortness of Breath	☐ Constipation	☐ Cancer	☐ Diverticulosis
☐ On Exertion	☐ Diabetes	☐ Nervousness	☐ Bloody/Tarry Stools
☐ Lying Flat	☐ Thyroid Disease	☐ Depression	☐ Chest Pain
☐ Hemorrhoids	☐ Convulsions/Seizures	☐ Memory Loss	☐ High Blood Pressure
☐ Gall Bladder Trouble	☐ Stroke	☐ Moodiness, Excessive	☐ Heart Murmur
☐ Jaundice/Hepatitis	☐ Tremor/Hand Shaking	☐ Mental Illness	☐ Palpitations
☐ Hernia	☐ Muscle Weakness	☐ Irregular Pulse	☐ Urine Infections, Frequent

MALES: ☐ Prostate Cancer ☐ Impotence

FEMALES: ☐ Pain with Menstrual Flow ☐ Pain/Bleeding after Sex ☐ Flushing/Menopause
Date of Last Mammogram: ☐ Cramps with Menstrual Flow Age of Onset:
Date of Last Pap Test: Menstrual Flow ☐ Regular ☐ Irregular
Date of 1st Day of Last Period: Birth Control Method:

No. of Pregnancies: _____ No. of Live Births: _____ No. of Miscarriages: _____

☐ Alcohol	Oz. Day/Week	_____	EXERCISE PREFERENCE:	_____
☐ Smoking	Cigarettes/Day	_____	AIDS Risk:	_____
☐ Coffee/Tea	Cups/Day		RELIGIOUS PREFERENCE:	

PHYSICAL EXAMINATION **DATE:** _____

VITALS **HT** _____ **WT** _____ **P** _____ **BP** _____ **RR** _____ **T** _____

GENERAL APPEARANCE

HEAD/NECK	**Neg/Defect**		***EXTREM***	**Neg/Defect**		***JOINTS***	**Neg/Defect**	
Head, Scalp	☐ ☐			st wk ab				
Head, Scalp	☐ ☐		Pulses-Fem	☐ ☐ ☐		Neck	☐ ☐	
Lids-Sclera	☐ ☐		Popliteal	☐ ☐ ☐		Shoulders	☐ ☐	
Eye Muscles	☐ ☐		Post Tibial	☐ ☐ ☐		Elbows	☐ ☐	
Pupils	☐ ☐		Dorsalis Ped	☐ ☐ ☐		Wrists	☐ ☐	
Fundi	☐ ☐		Varicose Vein	☐ ☐		Fingers	☐ ☐	
Ears	☐ ☐		Pedal Edema	☐ ☐		Back	☐ ☐	
Nose/Sinus	☐ ☐		***GENIT/URIN***	☐ ☐		Hips	☐ ☐	
Teeth/Gums	☐ ☐		***FEMALE***	☐ ☐		Knees	☐ ☐	
Pharynx	☐ ☐		Vulva/Vagina	☐ ☐		Ankles/Feet	☐ ☐	
Thyroid	☐ ☐		Adnexae	☐ ☐		***NEURO***	☐ ☐	
Neck Glands	☐ ☐		Cervix	☐ ☐		Paralysis	☐ ☐	
Carotid Bruit	☐ ☐		Uterus	☐ ☐		Gait	☐ ☐	
CHEST	☐ ☐		Uter/Recto	☐ ☐		Mus.Atrophy	☐ ☐	
Chest-Lungs	☐ ☐		Pap Test Done	**Yes** **No**		Cran.Nerves	☐ ☐	
Heart-Apex	☐ ☐			☐ ☐		Tendon Refl.	☐ ☐	
Heart Sounds	☐ ☐		***MALE***	☐ ☐		Romberg	☐ ☐	
Murm/Thrill	☐ ☐		Genitalia	☐ ☐		Babinski	☐ ☐	
Breast/Nipple	☐ ☐		Prostate	☐ ☐		Sensory	☐ ☐	
Axil. Nodes	☐ ☐		Tests	☐ ☐		Motor	☐ ☐	
ABDOMEN	☐ ☐		***DERM***	☐ ☐		Vibration	☐ ☐	
Abd. Mass	☐ ☐		Skin Lesions	☐ ☐		Position	☐ ☐	
Abd. Tend.	☐ ☐		Nail Beds	☐ ☐		Tremor	☐ ☐	
Hern. Rings	☐ ☐		Fingers	☐ ☐		Rigidity	☐ ☐	
Ing. Node	☐ ☐		Toes	☐ ☐			☐ ☐	

OTHER TESTS

ECG		Stool O&P			
Chest X-ray		Urine			
Pulm. Function		Hgb		WBC	
Mammogram		Chem Profile			
		Blood Sugar			

ASSESSMENT	**PLAN**
	☐ **PREVENTATIVE HEALTH PLAN**
	☐ **FPA HANDOUT**
	☐ **SPECIFICS**
	MEDICATION
Physician's Signature	
Family Practice Associates **1594 Kingsley Ave** **Orange Park, Florida 32073**	**RETURN VISIT**