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Manatee Primary Care Associates, LLC

Patient Medical and Family History

PATIENT NAME (last, first, MI):_____ Today's Date:_____

SSN:_____ DOB:_____ Account #:_____

DO YOU HAVE ALLERGIES: Yes No

IF YES, PLEASE LIST: _____

PLEASE LIST ALL MEDICATIONS THAT YOU ARE CURRENTLY TAKING:

Name: _____	Strength:_____	How Often:_____
Name: _____	Strength:_____	How Often:_____
Name: _____	Strength:_____	How Often:_____
Name: _____	Strength:_____	How Often:_____
Name: _____	Strength:_____	How Often:_____
Name: _____	Strength:_____	How Often:_____
Name: _____	Strength:_____	How Often:_____

PLEASE LIST ALL PREVIOUS SURGICAL PROCEDURES:

Type: _____	Year: _____	Type: _____	Year:
Type: _____	Year: _____	Type: _____	Year:
Type: _____	Year: _____	Type: _____	Year:

HAVE YOU EVER HAD THE FOLLOWING:

Diabetes	Yes	No	Controlled by:	Diet	Pills Insulin
High Cholesterol	Yes	No	Count & When: _____		
Stress Test	Yes	No	When & Where: _____		
Nuclear Stress Test	Yes	No	When & Where: _____		
Cardiac Catheterization	Yes	No	When & Where: _____		
PTCA (Angioplasty)	Yes	No	When & Where: _____		
Cardiac Bypass Surgery	Yes	No	When & Where: _____		
Pacemaker	Yes	No	When & Where: _____		
Heart Valve Replacement	Yes	No	When & Where: _____		
Defibrillator Implant	Yes	No	When & Where: _____		
Anemia	Yes	No	Hiatal Hernia	Yes	No
Gout	Yes	No	Arthritis	Yes	No
Stroke	Yes	No	Gallbladder Problems	Yes	No
Breathing Difficulties	Yes	No	Thyroid Problems	Yes	No
Palpitations	Yes	No	Kidney Problems	Yes	No
Heart Murmur	Yes	No	Ulcers	Yes	No
Abnormal Electrocardiogram	Yes	No	Bowel Problems	Yes	No
Rheumatic Fever	Yes	No	Psychiatric Problems	Yes	No
High Blood Pressure	Yes	No	Liver Problems	Yes	No
Angina	Yes	No	Heart Attack	Yes	No
Overweight	Yes	No			

DO YOU CURRENTLY USE TOBACCO: **Yes** **No**

If **Yes**, circle which: Cigars Cigarettes Pipe Chewing Tobacco

How many years?_____ How much per day?

HAVE YOU EVER USED TOBACCO: **Yes** **No**

If **Yes**, circle which: Cigars Cigarettes Pipe Chewing Tobacco

How many years?_____ How much per day?_____ Year You Quit:_____

Estimated Daily Consumption of Alcohol: _____

FAMILY HISTORY

Father Living: Yes No Age or Age @ Death:_____Cause of Death: _____

Mother Living: Yes No Age or Age @ Death:_____Cause of Death: _____

How many Brothers: _____ # Living:_____ # Dead:_____
Age/Cause of Death: _____

How many Sisters: _____ # Living:_____ # Dead:_____
Age/Cause of Death: _____

How many Children:_____ Ages: _____
Any Health Problems?:_____
If Yes, of what nature:_____

DO ANY OF THE FOLLOWING ILLNESSES RUN IN YOUR FAMILY?:

Diabetes: Yes No Which Member:_____
Stroke: Yes No Which Member:_____
Hypertension: Yes No Which Member:_____
Heart Disease: Yes No Which Member:_____

IS THERE ANYTHING ELSE WE SHOULD KNOW REGARDING YOUR HEALTH OR HISTORICAL BACKGROUND?

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