Family Medicine Of Weston LLC

Alberto Rengifo MD

Health History Form

Today's Date:

Name: _____ ***Age:*** _____ ***DOB:*** _____

Height: _____ *Weight:* _____

Allergies:Yes ☐ *To:* _____ *No:* ☐

Allergies to Medications: ☐*None* *List Medication Allergies:* _____

Current Medications: ☐*None* *1* _____ *3* _____

2 _____ *4* _____

Aspirin/Motrin/Advil	☐*Yes*	☐*No*	*Antiseizure Medications*	☐*Yes*	☐*No*	*Are you pregnant*	☐*Yes* ☐*No*
Coumadin	☐*Yes*	☐*No*	*Birth Control Pills*	☐*Yes*	☐*No*	*Plan on becoming pregnant*	☐*Yes* ☐*No*
Steroids	☐*Yes*	☐*No*	*Are you breast feeding*	☐*Yes*	☐*No*		

Review of Systems Screen ***(Current or past problems)***

Blood/Bleeding Disorders	☐*Yes*	☐*No*	*Arthritis*	☐*Yes*	☐*No*	*Cancer*	☐*Yes*	☐*No*
Heart Disease	☐*Yes*	☐*No*	*Diabetes*	☐*Yes*	☐*No*	*Immunologic Disease*	☐*Yes*	☐*No*
Kidney Disease	☐*Yes*	☐*No*	*High Blood Pressure*	☐*Yes*	☐*No*	*High Cholesterol/Trigl.*	☐*Yes*	☐*No*
Liver Disease or Hepatitis	☐*Yes*	☐*No*	*Infectious Disease (TB, HIV)*	☐*Yes*	☐*No*	*Nerve Disorders*	☐*Yes*	☐*No*
Lung Disease	☐*Yes*	☐*No*	*Received Blood Transfusion(s)*	☐*Yes*	☐*No*	*Skin Cancer*	☐*Yes*	☐*No*
Thyroid Disease	☐*Yes*	☐*No*	*Psychological Disorder(s)*	☐*Yes*	☐*No*	*Seizures*	☐*Yes*	☐*No*
Stroke	☐*Yes*	☐*No*	*Spine Disorder(s)*	☐*Yes*	☐*No*	*Brain Disorders*	☐*Yes*	☐*No*

Do you: *Have a pacemaker or defibrilator* ☐*Yes* ☐*No* *Have an artificial joint or heart valve* ☐*Yes* ☐*No*

List Surgeries:

1 _____ *4* _____

2 _____ *5* _____

3 _____ *6* _____

Family History ***(Check the following medical conditions which have occurred in your family)***

Disease	***Mother***	***Father***	***Blood Relative***	***None***	***Disease***	***Mother***	***Father***	***Blood Relative***	***None***
					Seizures	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	*Spine Disorders*	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	*Brain Disorders*	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	*Nerve Disorders*	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	*Stroke*	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	*High Chol/Trigl.*	☐	☐	☐	☐

Social History

Do you live alone?	☐*Yes*	☐*No*	*Do you drink alcohol?*	☐*Yes*	☐*No*	*Do you use recreational drugs?*	☐*Yes* ☐*No*
Do you smoke?	☐*Yes*	☐*No*	*Frequency*	_____		*Frequency*	_____
Frequency	_____						

Occupation: _____ *Hobbies/Leisure activities:* _____

Date of last colonsoscopy: _____ ***Date of last pap smear:*** _____ ***Date of last mammogram:*** _____

Patient Signature: _____ *Date:* _____