

# GMS FLORIDA WEST COAST, INC. - PATIENT HISTORY FORM

DATE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

NAME: \_\_\_\_\_ AGE: \_\_\_\_\_

**Family History:** For each family member below mark an "x" for all that apply to that person's health.

	HEALTH			Cause of death	Allergies/ Asthma	Stress/ depression	Kidney problems	Diabetes	High blood pressure	Heart trouble	Anemia Bleeding Issues	Cancer /Tumor
	Good	Poor	Deceased									
Father:												
Mother:												
Sibling:												
Sibling:												
Sibling:												
Sibling:												

**Your Health History**

Do you smoke? ( )Yes ( )No ( )Quit-When \_\_\_\_\_ How many packs per day? \_\_\_\_\_ How many years? \_\_\_\_\_  
 Do you drink alcohol/beer? ( )Yes ( )No How many drinks per day? \_\_\_\_\_ How many years? \_\_\_\_\_

**Additional Illnesses:** Mark an "X" in the boxes of the illnesses that you have or have ever had.

<input type="checkbox"/> eczema	<input type="checkbox"/> bronchitis	<input type="checkbox"/> pancreatitis	<input type="checkbox"/> mononucleosis	<b>List Others Below:</b>
<input type="checkbox"/> asthma	<input type="checkbox"/> measles	<input type="checkbox"/> liver disease	<input type="checkbox"/> german measles	<input type="checkbox"/> _____
<input type="checkbox"/> malaria	<input type="checkbox"/> pneumonia	<input type="checkbox"/> neuritis	<input type="checkbox"/> kidney trouble	<input type="checkbox"/> _____
<input type="checkbox"/> mumps	<input type="checkbox"/> hemorrhoids	<input type="checkbox"/> chicken pox	<input type="checkbox"/> yellow jaundice	<input type="checkbox"/> _____
<input type="checkbox"/> polio	<input type="checkbox"/> emphysema	<input type="checkbox"/> scarlet fever	<input type="checkbox"/> venereal disease	<input type="checkbox"/> _____
<input type="checkbox"/> hives/ rash	<input type="checkbox"/> diverticulosis	<input type="checkbox"/> thyroid disease	<input type="checkbox"/> rheumatic fever	<input type="checkbox"/> _____

Have you ever been turned down for life insurance, military service or employment because of your health?  yes  no

**Major Hospitalizations:** If you have ever been hospitalized for any serious medical illness or operation write them below starting with the most recent. (Do not include normal pregnancies.)  Check this box if you have had more than three hospitalizations.

Year hospitalized	Operation or illnesses	Name of hospital	City and state
1)	_____	_____	_____
2)	_____	_____	_____
3)	_____	_____	_____

**Allergies / Reaction:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Current Medical Problems**

**Current Medications (Including Strength and Dosage):**
