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.

☐ eczema	☐ bronchitis	☐ pancreatitis	☐ mononucleosis	List Others Below:
☐ asthma	☐ measles	☐ liver disease	☐ german measles	☐
☐ malaria	☐ pneumonia	☐ neuritis	☐ kidney trouble	☐
☐ mumps	☐ hemorrhoids	☐ chicken pox	☐ yellow jaundice	☐
☐ polio	☐ emphysema	☐ scarlet fever	☐ venereal disease	☐
☐ hives/ rash	☐ diverticulosis	☐ thyroid disease	☐ rheumatic fever	☐

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):

_____

_____

_____

_____

_____