GMS FLORIDA WEST COAST, INC. – PATIENT HISTORY FORM

Date: _____ Name: _____ DOB:_____

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	Fair	Deceased									
Father												
Mother												
Sibling												
Sibling												

Your Health History

Do you smoke? ☐Yes ☐No ☐Quit. When_____ How many packs per day? How many years?

Additional Illnesses: Mark an "X" in the appropriate boxes for illnesses you have or have ever had.

Medical Illness		Past	Present	Medical Illness		Past	Present
BLOOD:	Anemia			GI:	GERD/HEARTBURN/REFLUX		
	Bleed Disorders				Colon Polyps		
	Blood Clots				Irritable Bowel Syndrome (IBS)		
HEART:	Heart Disease				Liver Disease		
	History of Heart Attack (MI) Year:			NEURO:	CVA (stroke)		
	Hypertension(High Blood Pressure)				Parkinson's Disease		
	Elevated Cholesterol				Neuropathy		
ENDOCRINE:	Diabetes			PULMONARY:	Emphysema/COPD		
	Hypothyroid (low)				Asthma		
	Hypothyroid (high)			CANCER:	Location		
	Goiter				Location		
VASCULAR DISEASE				SKIN CONDITION			
KIDNEY DISEASE				OTHER			
URINARY CONDITION & PROSTATE				OTHER			

	MAJOR HOSPITALIZATIONS LAST 3 YEARS			
Year	**Surgery / Procedure**	**Hospitalizations**	**Reason**	**Date**

Current Medications		
Name of Medication	**Strength**	**Times per day**

Allergies	
Allergen/Medication	**Reaction**