Name: _____
DOB: _____

FLORIDA ATLANTIC UNIVERSITY
MEDICAL GROUP

PATIENT HISTORY

Preventive Health

Immunization	Date Performed	Screening Test	Date Performed
COVID-19		Colonoscopy/Cologuard	
Influenza Vaccination		Mammogram	
Prevnar (1st Pneumonia shot)		PAP	
Pneumovax(2nd Pneumonia		PSA (Prostate)	
Tetanus Vaccination		DEXA/ bone density	
TDAP (Whooping cough)		Breast ultrasound	
Zostavax (Shingles vaccine)			
Shingrix (Shingles vaccine)			

Medications

Please list all medications you are taking currently, including over the counter and herbal remedies.

Medication Name: **Dosage (mg, cc, etc)** **Frequency (how often)**

Past Medical History

Please mark any current or previous illnesses or health problems.

- ☐ ADD/ ADHD
- ☐ Anxiety
- ☐ Anemia
- ☐ Arthritis
- ☐ Bipolar Disorder
- ☐ Blood Clots
- ☐ Cancer (type)_____
- ☐ COPD
- ☐ Chronic Pain related to _____
- ☐ Depression
- ☐ Degenerative Joint Disease
- ☐ Diabetes Mellitus
- ☐ Drug/ Alcohol Addiction
- ☐ Female Problems
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High Cholesterol
- ☐ HIV/ AIDS
- ☐ Kidney Disease
- ☐ Lupus
- ☐ Lung Problems
- ☐ Male Problems
- ☐ Parkinson's Disease
- ☐ Rheumatoid Arthritis
- ☐ Seizure Disorder
- ☐ Schizophrenia
- ☐ Stroke
- ☐ Thyroid Diesease

Allergies

Please list all food and drug allergies:

Name: _____
DOB: _____

Surgical History / Major Diagnostic Procedures

- ☐ Appendectomy
- ☐ Back Surgery
- ☐ Bariatric Surgery
- ☐ Breast
  (was surgery involved _____)
- ☐ C-Section
- ☐ Gall Bladder
- ☐ Lung Biopsy
- ☐ Heart Catheterization
- ☐ Heart Bypass Surgery
- ☐ Prostate Surgery
- ☐ Other: _____
- ☐ Hysterectomy
  (was cancer involved____)
- ☐ Tonsillectomy
- ☐ Tumor Removal
- ☐ Vasectomy

Hospitalizations/Emergency Room Visits

Reason:	**Date:**

Social History

Have you ever smoked? (cigarettes, vape, cigars, etc.) ☐ No ☐ Yes

How many per day? _____ How many years? Stop date: _____

Do you drink alcohol? ☐ No ☐ Yes How many drinks per week? _____

Do you use any street drugs? ☐ No ☐ Yes If yes, please list _____

Family History

Are you adopted? Yes ☐ No ☐

	Father	Mother	Siblings	Children
Living	☐	☐	☐	☐
Deceased	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐
Cancer (type)	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐
Blood Clots	☐	☐	☐	☐
Lung Disease	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐
Headaches	☐	☐	☐	☐
Seizure	☐	☐	☐	☐
COPD/Emphysema	☐	☐	☐	☐
Other (specify)	☐	☐	☐	☐
Unknown	☐	☐	☐	☐