TLC Family Medical & Rehab Center

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Phone: 813.884.2300 • Fax: 813.884.2390

11357 Countryway Boulevard, Tampa, Florida 33626
Phone: 813.925.8800 • Fax: 813.925.8840

Patient Medical History

Date: _____

Patient's Name: _____ (Last) _____ (First) _____ (Middle) _____ (Nickname)

Date of birth: _____ Age _____ Sex: ☐M ☐F

Reason for today's visit: _____

Drug Allergies ☐ None

_____

_____

☐ List attached ☐ Continued on other side

Current Medications: ☐ None

_____

_____

_____

_____

_____

☐ List attached ☐ Continued on other side

Hospitalization or Surgery ☐ None

Reason	Date

☐ List attached ☐ Continued on other side

MEN only: Has anyone in the family has testicular or prostrate cancer? ☐Yes ☐No

WOMEN only:
Pregnant? ☐Yes ☐No Planning pregnancy? ☐Yes ☐No
Has anyone in the family had breast, ovarian, uterine, cervical or Vulva cancer? ☐Yes ☐No
Last day of Menstrual Period: _____ ☐ Regular ☐Irregular
Menopause: ☐ Yes ☐ No How many years ago? _____

Family History

	Father	Mother	Father's Parents	Mother's Parents	☐B ☐S Sibling	☐S ☐D Child
Heart Disease	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐
Alzheimer's Disease	☐	☐	☐	☐	☐	☐
Parkinson's Disease	☐	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐	☐

Habits:

☐ **Smoke:** Packs daily____ / How long? _____
If quit, when?_____ / Interested in stopping? ☐Yes ☐No
☐ **Exercise Routine:** _____
☐ **Coffee:** Cups daily_____ / Other caffeine _____
☐ **Alcohol:** Type_____ / Amount _____
☐ **Sleep:** ☐Difficulty falling asleep ☐Continuity Disturbances ☐Daytime drowsiness ☐Sleep Apnea HX ☐Snoring ☐Early Morning Awakening

Hepatitis C Risk Factor:

☐ Blood transfusion prior to 1992
☐ Contact with blood/bodily fluid
☐ Shared razor/toothbrush
☐ History of Hepatitis B
☐ Tattoos
☐ Body Piercing
☐ History of STDs / TB
☐ IV Drug use (1+ times)

Medical History (check all that apply)

☐ Headache
☐ Shortness of Breath
☐ Heart Palpitations
☐ Heart Murmur
☐ Chest Pain
☐ Dizziness / Fainting
☐ Heart Attack
☐ Allergies / Hay Fever
☐ Asthma
☐ Bronchitis
☐ Pneumonia
☐ Stomach Ulcer
☐ Cancer _____
☐ Lactose Intolerance
☐ Gallbladder Disease
☐ Prostrate Disease
☐ Bowel Irregularity / IBS
☐ Urinary Incontinence
☐ Sexual Menstrual Dysfunction
☐ Venereal Disease (STDs)
☐ Frequent Infections
☐ Hepatitis A / B / C
☐ Liver Disease / Cirrhosis
☐ Rheumatoid Arthritis
☐ Osteoarthritis
☐ Kidney Disease
☐ Osteoporosis
☐ Nervousness / Anxiety / Panic Attack
☐ Depression
☐ Gout
☐ Chronic Rashes / Hives
☐ Rheumatic Fever
☐ Seizure Disorder
☐ Congestive Heart Failure
☐ Emphysema / COPD
☐ Blood Clots / DVT
☐ Anemia
☐ Leg Swelling
☐ Diabetes____years
☐ HIV / AIDS
☐ Stroke
☐ Memory Loss
☐ TB / Lung Disease
☐ Hypertension____years
☐ High Cholesterol
☐ Glaucoma / Cataract
☐ _____
☐ _____
☐ _____
☐ _____

Signature of Patient (or Guardian): _____ Date: _____

Reviewed by: _____ Date: _____