

8570 Granite Court • Fort Myers, FL 33908
Phone (239) 313-2740 • Fax (239) 313-2741

 11181 Health Park Blvd., Suite 3020 • Naples, FL 34110
Phone (239) 653-9118 • Fax (239) 653-9108

Patient Name _____, _____ |

CONFIDENTIAL OFFICE USE ONLY

Date: __/__/____

Name: _____
Last First Middle

Date of Birth: __/__/____ Age: _____ Phone: __ - __ - ____

Referring Physician: _____
Family Physician: _____

Please answer all questions below. If you are unable to answer any question, please circle it and call it to the attention of the examining doctor.

HISTORY OF PRESENT ILLNESS:

What problem brings you to this office? _____

Do you have a history of :
 Blood Disease YES NO When? _____
 Cancer YES NO When? _____
 Other YES NO When? _____

If yes, what type? _____

Prior Treatment:				X-Ray Treatment of:			
Chemotherapy / Drug	<input type="checkbox"/> YES	<input type="checkbox"/> NO	When? _____	Skin	<input type="checkbox"/> YES	<input type="checkbox"/> NO	When? _____
Radiation	<input type="checkbox"/> YES	<input type="checkbox"/> NO	When? _____	Thyroid	<input type="checkbox"/> YES	<input type="checkbox"/> NO	When? _____
Surgery	<input type="checkbox"/> YES	<input type="checkbox"/> NO	When? _____	Tonsils	<input type="checkbox"/> YES	<input type="checkbox"/> NO	When? _____
Other	<input type="checkbox"/> YES	<input type="checkbox"/> NO	When? _____				

MEDICATIONS: List all medications you take (prescription and over the counter)

Medication	Dosage	Times Per Day	How long have you taken the medication

Have you ever been told to take antibiotics before or after dental procedures? YES NO

Do you have any drug allergies or allergies? YES NO Allergic to what? _____

If yes, what type of reaction? _____

PRIOR BLOOD TRANSFUSIONS: YES NO When? _____

VACCINATIONS RECEIVED:
 Flu YES NO When? _____ Hepatitis YES NO When? _____
 Pneumovax YES NO When? _____

OTHER MEDICAL PROBLEMS (Diabetes, Hypertension etc.)

Date	Doctor	Diagnosis

Please List all hospitalizations and surgeries (if none, PLEASE write "none").

Year	Duration	Reason / Result	Hospital / Physician

Additional Information

Any recommended surgical operations which you have not undergone? YES NO

If yes, describe: _____

OCCUPATIONAL EXPOSURE

Have you had exposure to:	YES	NO	WHEN	YES	NO	WHEN	
Asbestos				Agent Orange			
Toxic Metals or Radioactive Material				Worked in a Mine			
Vinyl Chloride or Toxic Chemicals				Lived on a Farm			

SOCIAL HISTORY

Marital Status S M D W

Current Occupation: _____

If retired, last employment: _____

Do you smoke cigarettes? YES NO Have you ever smoked cigarettes? YES NO

If yes, how many packs per day? _____ for how many years? _____ When did you quit? _____

Do you drink alcohol? YES NO If yes, average daily consumption? _____ for _____ years.

Education (circle last year completed)

GRADE SCHOOL: 7 8 9 10 11 12 COLLEGE: 1 2 3 4 POST GRADUATE

Do you live alone? YES NO If not, with whom? _____

Who can you depend on? _____

Do you drive? YES NO

Do you have a Living Will? YES NO

Patient Name _____

FAMILY HISTORY

	YES	NO	Family Member		YES	NO	Family Member
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Strokes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Melanoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	_____	Bleeding Tendency	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____				

Additional Information

FAMILY MEDICAL STATUS

Present age or age at death	Living	Dead	Medical problems or cause of death	Present age or age at death	Living	Dead	Medical problems or cause of death
Father Age _____	<input type="checkbox"/>	<input type="checkbox"/>		Mother Age _____	<input type="checkbox"/>	<input type="checkbox"/>	
Brother Age _____	<input type="checkbox"/>	<input type="checkbox"/>		Sister Age _____	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	

Significant illness in children: _____

Additional Information

REVIEW OF SYSTEMS

CONSTITUTIONAL				NEUROLOGIC			
Symptoms	YES	NO	When	Symptoms	YES	NO	When
Weight Loss _____ lbs	<input type="checkbox"/>	<input type="checkbox"/>		Pain, if yes see below	<input type="checkbox"/>	<input type="checkbox"/>	
Weight Gain _____ lbs	<input type="checkbox"/>	<input type="checkbox"/>		Where / Intensity /Duration:			
Chills or Fever	<input type="checkbox"/>	<input type="checkbox"/>		Headaches	<input type="checkbox"/>	<input type="checkbox"/>	
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>		Insomnia	<input type="checkbox"/>	<input type="checkbox"/>	
Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>		Seizures-Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	
Are you up most of the day?	<input type="checkbox"/>	<input type="checkbox"/>		Memory Defect	<input type="checkbox"/>	<input type="checkbox"/>	
In bed more than half the time?	<input type="checkbox"/>	<input type="checkbox"/>		Balance Problems	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Left Handed				Difficulty Walking in the Dark	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Right Handed				Numbness & Tingling Extremities	<input type="checkbox"/>	<input type="checkbox"/>	
				Shaking or Tremor of Hands	<input type="checkbox"/>	<input type="checkbox"/>	

EYES, EARS, NOSE, THROAT, MOUTH

SYMPTOMS	YES	NO	When
Eye Surgery Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	
Vision Change	<input type="checkbox"/>	<input type="checkbox"/>	
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	
Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	
Ear Aches	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty Swallowing	<input type="checkbox"/>	<input type="checkbox"/>	
Sinus Infections	<input type="checkbox"/>	<input type="checkbox"/>	
Sore Throats	<input type="checkbox"/>	<input type="checkbox"/>	

Additional symptoms:

<u>CARDIOVASCULAR</u>							
Have you had:	YES	NO	When		YES	NO	When
Shortness of Breath with Exercise	<input type="checkbox"/>	<input type="checkbox"/>		Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	
Ankle Swelling	<input type="checkbox"/>	<input type="checkbox"/>		Stroke or Paralysis	<input type="checkbox"/>	<input type="checkbox"/>	
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>		Circulation Problems	<input type="checkbox"/>	<input type="checkbox"/>	
Rapid Heart Beat	<input type="checkbox"/>	<input type="checkbox"/>		Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>		Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	
Fainting Spells	<input type="checkbox"/>	<input type="checkbox"/>		Heart Valve Problem	<input type="checkbox"/>	<input type="checkbox"/>	
Chest Pain or Pressure-Angina	<input type="checkbox"/>	<input type="checkbox"/>		Heart Infection	<input type="checkbox"/>	<input type="checkbox"/>	
Leg Cramps	<input type="checkbox"/>	<input type="checkbox"/>		Sleep on _____pillows	<input type="checkbox"/>	<input type="checkbox"/>	

Additional Information

<u>RESPIRATORY</u>							
Have you had:	YES	NO	When		YES	NO	When
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>		Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	
Coughed up Blood	<input type="checkbox"/>	<input type="checkbox"/>		Shortness of Breath at Night	<input type="checkbox"/>	<input type="checkbox"/>	
Asthma or Wheezing	<input type="checkbox"/>	<input type="checkbox"/>		Pleurisy	<input type="checkbox"/>	<input type="checkbox"/>	
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>		Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	
Sputum Production	<input type="checkbox"/>	<input type="checkbox"/>		Blood Clot in Lung	<input type="checkbox"/>	<input type="checkbox"/>	

Additional Information

<u>GASTROINTESTINAL</u>							
Have you had:	YES	NO	When		YES	NO	When
Increased Appetite	<input type="checkbox"/>	<input type="checkbox"/>		Abdominal Swelling	<input type="checkbox"/>	<input type="checkbox"/>	
Decreased Appetite	<input type="checkbox"/>	<input type="checkbox"/>		Change in Bowel Movement	<input type="checkbox"/>	<input type="checkbox"/>	
Nausea and Vomiting	<input type="checkbox"/>	<input type="checkbox"/>		Constipation	<input type="checkbox"/>	<input type="checkbox"/>	
Abdominal Pain or Cramps	<input type="checkbox"/>	<input type="checkbox"/>		Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	
Ulcer Disease	<input type="checkbox"/>	<input type="checkbox"/>		Blood in Bowel Movement	<input type="checkbox"/>	<input type="checkbox"/>	
Yellow Jaundice-Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>		Black Bowel Movement	<input type="checkbox"/>	<input type="checkbox"/>	
Liver Disease-Cirrhosis	<input type="checkbox"/>	<input type="checkbox"/>		Diverticulitis	<input type="checkbox"/>	<input type="checkbox"/>	
Gall Bladder Problem - Gallstone	<input type="checkbox"/>	<input type="checkbox"/>		Colitis	<input type="checkbox"/>	<input type="checkbox"/>	
Pancreatic Disease	<input type="checkbox"/>	<input type="checkbox"/>		Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	

Additional Information

GENITOURINARY

Have you had:	YES	NO	When		YES	NO	When
Frequent Urination	<input type="checkbox"/>	<input type="checkbox"/>		Urinate during the night How many times _____	<input type="checkbox"/>	<input type="checkbox"/>	
Painful Urination	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	
Blood in Urine	<input type="checkbox"/>	<input type="checkbox"/>		Pain in Testicles (men)	<input type="checkbox"/>	<input type="checkbox"/>	
Cystitis	<input type="checkbox"/>	<input type="checkbox"/>		Prostate Problems (men)	<input type="checkbox"/>	<input type="checkbox"/>	
Incontinence	<input type="checkbox"/>	<input type="checkbox"/>		Loss of Sexual Potency (men)	<input type="checkbox"/>	<input type="checkbox"/>	
Kidney Stone	<input type="checkbox"/>	<input type="checkbox"/>		Swelling of Breast (men)	<input type="checkbox"/>	<input type="checkbox"/>	
Hernia	<input type="checkbox"/>	<input type="checkbox"/>		Hard to Start Urine (men)	<input type="checkbox"/>	<input type="checkbox"/>	
Bloody or Other Discharge	<input type="checkbox"/>	<input type="checkbox"/>		Testicular Mass (men)	<input type="checkbox"/>	<input type="checkbox"/>	
Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>		Decreased Urine Flow (men)	<input type="checkbox"/>	<input type="checkbox"/>	

Additional Information

MUSCULOSKELETAL

Have you had:	YES	NO	When		YES	NO	When
Arthritis-Type	<input type="checkbox"/>	<input type="checkbox"/>		Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	
Muscle Pain or Cramps	<input type="checkbox"/>	<input type="checkbox"/>		Joint Replacement	<input type="checkbox"/>	<input type="checkbox"/>	
Painful or Swollen Joints	<input type="checkbox"/>	<input type="checkbox"/>		History of Fracture	<input type="checkbox"/>	<input type="checkbox"/>	
Lupus	<input type="checkbox"/>	<input type="checkbox"/>		Loss of Limb	<input type="checkbox"/>	<input type="checkbox"/>	
Gout	<input type="checkbox"/>	<input type="checkbox"/>		Bone Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Backaches	<input type="checkbox"/>	<input type="checkbox"/>		Laminectomy-Disc Disease	<input type="checkbox"/>	<input type="checkbox"/>	

Additional Information

ENDOCRINE

HEMATOLOGY

Have you had:	YES	NO	When	Have you had:	YES	NO	When
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>		Tendency to Bleed or Bruise Easily	<input type="checkbox"/>	<input type="checkbox"/>	
Heat Intolerance	<input type="checkbox"/>	<input type="checkbox"/>		Lymph Node Enlargement	<input type="checkbox"/>	<input type="checkbox"/>	
Bleeding after Tooth Extraction	<input type="checkbox"/>	<input type="checkbox"/>		Frequent Nose Bleed	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>		Bleeding after Tooth Extraction	<input type="checkbox"/>	<input type="checkbox"/>	
Adrenal Disease	<input type="checkbox"/>	<input type="checkbox"/>		White Blood Cell Problem	<input type="checkbox"/>	<input type="checkbox"/>	
Hair Loss or Gain	<input type="checkbox"/>	<input type="checkbox"/>		Platelet Problem	<input type="checkbox"/>	<input type="checkbox"/>	
Voice Change	<input type="checkbox"/>	<input type="checkbox"/>		Anemia	<input type="checkbox"/>	<input type="checkbox"/>	
Salt Loss or Water Retention	<input type="checkbox"/>	<input type="checkbox"/>		History of Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	
				Abnormal Spleen	<input type="checkbox"/>	<input type="checkbox"/>	
				Blood Clots; Treatment	<input type="checkbox"/>	<input type="checkbox"/>	

Additional Information

Patient Name _____

				FEMALE			
Have you had:	YES	NO	When	Have you had:	YES	NO	When
History of Menstrual Irregularity	<input type="checkbox"/>	<input type="checkbox"/>		Breast Discharge	<input type="checkbox"/>	<input type="checkbox"/>	
Vaginal Bleeding Currently	<input type="checkbox"/>	<input type="checkbox"/>		Breast Swelling	<input type="checkbox"/>	<input type="checkbox"/>	
Use of Hormones during Menopause	<input type="checkbox"/>	<input type="checkbox"/>		Breast Pain	<input type="checkbox"/>	<input type="checkbox"/>	
Breast Fed Infant	<input type="checkbox"/>	<input type="checkbox"/>		Breast Mass	<input type="checkbox"/>	<input type="checkbox"/>	
Age at Menopause	<input type="checkbox"/>	<input type="checkbox"/>		Breast Biopsy	<input type="checkbox"/>	<input type="checkbox"/>	
Age of first Menses (Period)	<input type="checkbox"/>	<input type="checkbox"/>		Abnormal Mammogram	<input type="checkbox"/>	<input type="checkbox"/>	
Number of times Pregnant	<input type="checkbox"/>	<input type="checkbox"/>		Vaginal Discharge	<input type="checkbox"/>	<input type="checkbox"/>	
Number of Live Births	<input type="checkbox"/>	<input type="checkbox"/>		Pelvic Pain	<input type="checkbox"/>	<input type="checkbox"/>	
Age at first Delivery	<input type="checkbox"/>	<input type="checkbox"/>		D&C	<input type="checkbox"/>	<input type="checkbox"/>	
Means of Birth Control	<input type="checkbox"/>	<input type="checkbox"/>		Hysterectomy	<input type="checkbox"/>	<input type="checkbox"/>	
Last Menstrual Period	<input type="checkbox"/>	<input type="checkbox"/>		Removal of Ovaries	<input type="checkbox"/>	<input type="checkbox"/>	
Last Mammogram	<input type="checkbox"/>	<input type="checkbox"/>					
Last Pap Smear	<input type="checkbox"/>	<input type="checkbox"/>					

Additional Information

INTEGUMENTARY (Skin)				PSYCHIATRIC			
Have you had:	YES	NO	When	Have you had:	YES	NO	When
Red / Blot Areas	<input type="checkbox"/>	<input type="checkbox"/>		Depression	<input type="checkbox"/>	<input type="checkbox"/>	
Dark Moles	<input type="checkbox"/>	<input type="checkbox"/>		Mood Swings	<input type="checkbox"/>	<input type="checkbox"/>	
Rash / Itching	<input type="checkbox"/>	<input type="checkbox"/>					

Additional Information

Notes

Did someone other than patient complete this form? Yes No

If yes, your relationship to patient: _____

Patient Signature: _____

Date: _____

Would you like a copy of this questionnaire? Yes No