Infectious Diseases Associates
OF NORTH CENTRAL FLORIDA

Tel: (352) 622-2020
Fax: (352) 622-2025
3306 SW 26th Ave. #104
Ocala, Florida 34471
www.IDocala.com

PAST MEDICAL HISTORY

NAME: ______________________________ **DOB:** ______________

Have you seen any physicians in the last 2 years? If so, please list below:

PHYSICIAN	**REASON**
1.____________________	____________________
2.____________________	____________________
3.____________________	____________________
4.____________________	____________________

___ Alcoholism
___ Allergies/Hayfever
___ Anemia
___ Anxiety
___ Asthma
___ Atrial Fibrillation
___ Blood Transfusion
___ CAD
___ Cancer type: ___________
___ Cardiovascular Disease
___ CHF
___ Chronic Renal Insufficiency
___ Cirrhosis
___ Colitis
___ Colon Polyps
___ COPD
___ CRF
___ Crohn's Disease
___ CVA
___ Diverticulosis
___ Depression
___ Diabetes Type 1
___ Diabetes Type 2
___ DVT
___ Epilepsy
___ Fracture
___ GI Bleed
___ Gastrointestinal Disease
___ GERD
___ Gout
___ Heart Murmur
___ Hepatitis
___ High Cholesterol
___ HIV
___ Hyperlipidemia
___ Hypertension
___ Hyperthyroidism
___ Hypothyroidism
___ IV Drug use
___ Joint Pain
___ Kidney Infections
___ Kidney Stone
___ Ulcer Disease
___ Lyme's Disease
___ Migraines
___ Multiple Sclerosis
___ Obesity
___ Old MI
___ Osteoarthritis
___ Osteomyelitis
___ Osteoporosis
___ Peripheral Vascular Disease
___ Pneumonia
___ Pulmonary Disease
___ Rheumatic Fever
___ Rheumatoid Arthritis
___STD
___Thyroid Disease
___ TIA
___ Tuberculosis
___ Venereal Disease
___ Liver Disease
___ Emphysema
___ Lung Disease
___ Back Pain

OTHER MEDICAL HISTORY:

Surgical Procedures

___ No prior surgical History
___ Appendectomy
___ Breast Lumpectomy
___ Cataract Surgery
___ Colon Surgery
___ C-section
___ Endometrial Ablation
___ Gall Bladder
___ Heart Surgery
___ Hemorrhoids
___ Hernia
___ Hysterectomy
___ Laparoscopy
___ Mastectomy L Or R
___ Myomectomy
___ Oophorectomy
___Tonsil/Adenoidectomy
___ Tubal Ligation

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OTHER SURGICAL HISTORY:

Social History

__ Drug Use
__ Sun Protection
__ Tattoos
__ Sexual Activity
__ Physical Abuse
__ Domestic Violence
__ Seatbelts
__ Body Piercings

Tobacco Use __ YES __ NO Date Quit ______
TYPE: _____ SMOKELESS OR ____ SMOKING
Alcohol Use _____ Amount per day ________
Caffeine Use _____Amount per day ________

Preventive Care

Date

Flu Shot ____________________
Zoster Vaccine ________________
Chlamydia Screening ___________
Colonoscopy__________________
Dilated Eye Exam ______________
Flexible Sigmoidoscopy _________

Date

Pneumonia Vaccine __________
HIV Test ___________________
Mammogram ________________
Pap Smear __________________
Stool Occult Blood ___________

Family History

__ Adopted
__ Unknown Paternal History
__ Alcoholism
__ Anemia
__ Anxiety
__ Asthma
__ Birth Defects
__ CAD
__ Cardiovascular Disease
__ CHF
__ Cancer type: ____________

__ Denial of any knowledge of significant family history
__ Unknown Maternal History
__ Congenital Anomaly
__ COPD
__ Crohn's Disease
__ Depression
__ Diabetes
__ Epilepsy
__ GERD
__Hypercholesterolemia
__ Hyperlipidemia

__ Hypertension
__ Hypothyroidism
__ Kidney Disease
__ Liver Disease
__ Multiple Births
__ Osteoarthritis
__ Osteoporosis
__ Pulmonary Disease
__ Stroke

DRUG ALLERGIES REACTION

____
____

PHARMACY: ____

______________ ______________ ______________
Phone Number City Street

MEDICATIONS: *** If you have a list of medications, that you take, we can make a copy of that****

CURRENT MEDICATIONS	DOSE	FREQUENCY