LIST ALL ***MEDICATIONS & SUPPLEMENTS***:

Medication / Dose	Frequency	Medication / Dose	Frequency	Medication / Dose	Frequency
1.		5.		9.	
2.		6.		10.	
3.		7.		11.	
4.		8.		12.	

LIST ALL ***ALLERGIES* and *REACTIONS*** YOU HAVE TO MEDICATIONS:

____

____

REASON FOR TODAY'S VISIT: (Please describe): ____

____

MEDICAL CONDITIONS TREATED NOW OR IN THE PAST: (Please check all that apply)

____ Angina
____ Arthritis of __________________
____ Asthma
____ Black Lung Disease
____ Bleeding Disorder
____ Blood Clots
____ Blurred Vision
____ Bowel/Digestive Problems
____ Cancer of __________________
____ C.O.P.D./Emphysema
____ Depression/Anxiety
____ Diabetes
____ Dialysis Treatments
____ Difficulty Swallowing
____ Dizziness / Balance
____ End Stage Renal Disease
____ Fibromyalgia
____ Headaches
____ Heart Attack/Heart Failure
____ High Cholesterol
____ Hypertension / Hypotension
____ Irregular Heart Rhythm
____ Kidney Stones
____ Numbness
____ Osteoporosis
____ Pneumonia
____ Prostate Enlargement
____ Recent Fall
____ Seizures
____ Sinus/Allergies
____ Skin Condition
____ Stomach Ulcers/Reflux Disease
____ Stroke
____ Swelling of extremities
____ Thyroid
____ Unexplained Weight Changes
____ Urinary Infections
____ Other: ______________________
____

PAST SURGICAL HISTORY: (Please check all that apply)

____ Abdominal Aneurysm
____ Appendectomy
____ Back
____ Brain
____ Breast R / L / Both
____ Carotid Artery
____ Gallbladder
____ Heart Bypass / Pacemaker / Stents
____ Hysterectomy
____ Joint Replacement of _________
____ Leg Artery Bypass R / L
____ Neck
____ Prostate Surgery/Radiation
____ Tonsillectomy
____ Other: ______________________

FAMILY MEDICAL HISTORY: (Please check all that apply)

❑ Heart Disease ❑ High Blood Pressure ❑ Diabetes ❑ Cancer ❑ Other: ______________________

SOCIAL HISTORY:

Do you have recent thoughts of harming yourself or others? . . . ❑ Yes ❑ No

Do you feel safe at home? . . . . ❑ Yes ❑ No

In what language, if other than English, do you best learn? ______________________

Do you have any learning challenges due to: ❑ Cultural/religious beliefs ❑ Physical limitations ❑ Emotional barriers ❑ Limitations in understanding or communication ❑ Desire/motivation to learn

Do you learn better by hearing/reading/doing something? ❑ Hearing ❑ Reading ❑ Doing

Tobacco Use: . . . . . . ❑ Yes ❑ Never ❑ Quit (When?) ____________ If Yes, Packs Per Day? ____________

Do You Drink Alcohol? . . . . ❑ Yes ❑ No

How Much Per Day? ____________

Health Maintenance:
Pneumonia Shot / Date: __________
Shingles Shot/Date: ___________
Tetanus Booster/Date: ___________
Flu Shot / Date: ______________

PATIENT'S FULL NAME: ______________________________________

DON'T FORGET TO LABEL ALL COPIES. IF NO LABEL, MUST INDICATE PATIENT NAME, DATE OF BIRTH AND DOCTOR

PATIENT NAME
DATE OF BIRTH
DOCTOR:

PLACE PATIENT ID LABEL HERE

SARASOTA MEMORIAL HEALTH CARE SYSTEM

OUTPATIENT MEDICAL QUESTIONNAIRE