

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)

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

PAST SURGICAL HISTORY: (Please check all that apply)

- | | | |
|--|--|---|
| <input type="checkbox"/> Abdominal Aneurysm | <input type="checkbox"/> Carotid Artery | <input type="checkbox"/> Leg Artery Bypass R / L |
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Gallbladder | <input type="checkbox"/> Neck |
| <input type="checkbox"/> Back | <input type="checkbox"/> Heart Bypass / Pacemaker / Stents | <input type="checkbox"/> Prostate Surgery/Radiation |
| <input type="checkbox"/> Brain | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> Breast R / L / Both | <input type="checkbox"/> Joint Replacement of _____ | <input type="checkbox"/> 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: _____

SARASOTA MEMORIAL HEALTH CARE SYSTEM

OUTPATIENT MEDICAL QUESTIONNAIRE



<i>DON'T FORGET TO LABEL ALL COPIES. IF NO LABEL, MUST INDICATE PATIENT NAME, DATE OF BIRTH AND DOCTOR</i>
PATIENT NAME
DATE OF BIRTH
DOCTOR:
PLACE PATIENT ID LABEL HERE

SARASOTA MEMORIAL PATIENT DEMOGRAPHIC FORM

PATIENT LEGAL NAME:

LAST: _____ FIRST: _____ MI: _____

PATIENT BILLING ADDRESS: _____

CITY: _____ ST: _____ ZIP: _____

PATIENT PHONE#: _____ CELL#: _____

DATE OF BIRTH: _____ SEX (CIRCLE) M/ F / OTHER SOCIAL SECURITY#: _____

EMAIL ADDRESS: _____ VETERAN: YES/ NO ACTIVE DUTY: YES /NO

MARITAL STATUS (CIRCLE): SINGLE MARRIED DIVORCED WIDOWED

DO YOU CONSIDER YOURSELF TO BE OF HISPANIC OR LATINO CULTURE? YES NO

RACE (CIRCLE ALL THAT APPLY) AMERICAN INDIAN/ESKIMO HISPANIC/HISPANIC CULTURE ASIAN
WHITE/CAUCASIAN BLACK/AFRICAN AMERICAN HAWAII NATIVE/PAC ISLANDER OTHER

PREFERRED LANGUAGE: ENGLISH / SPANISH/ RUSSIAN / FRENCH / OTHER _____

LOCAL (FLORIDA ONLY) PRIMARY CARE DOCTOR: _____

EMERGENCY CONTACT PERSON: _____

PHONE #: _____ RELATION: _____

PATIENT EMPLOYMENT STATUS: UNEMPLOYED / FULL TIME / PART TIME / DISABLED / RETIRED (DATE): _____

EMPLOYER: _____ POSITION: _____ PHONE #: _____

IF PATIENT IS A MINOR, PLEASE FILL IN INFORMATION BELOW FOR THE PERSON BRINGING IN THE PATIENT:

LEGAL NAME: _____ DOB: _____ RELATIONSHIP TO MINOR: _____

INSURANCE SUBSCRIBER INFORMATION FOR PRIMARY INSURANCE, IF NOT PATIENT:

PRIMARY POLICY HOLDER IS (CIRCLE): SPOUSE MOTHER/FATHER OTHER: _____

LEGAL NAME: _____ DOB: _____ SSN: _____

ADDRESS OF PRIMARY HOLDER: (IF NOT THE SAME AS PATIENT ADDRESS)

_____ CITY: _____ STATE: _____ ZIP: _____

EMPLOYMENT STATUS OF SUBSCRIBER: UNEMPLOYED / FULL TIME / PART TIME / DISABLED / RETIRED (DATE): _____

PATIENT LABEL HERE
12/1/17