CARLOS SILVA, M.D., P.A.
BOARD CERTIFIED IN INTERNAL MEDICINE/FAMILY PRACTICE
4446 EAST FLETCHER AVE, SUITE D, TAMPA FL 33613
PHONE: 813-972-2974 FAX: 813-866-7227

Please verify the information is correct. Please make any necessary corrections and sign and date this form.

Patient Name: **Patient DOB:** **Patient SSN:**
Patient Primary Address:
Patient Home Phone Number: **Patient Cell Number:**

Race:
- ☐ White
- ☐ Black or African American
- ☐ Hispanic
- ☐ Asian
- ☐ American Indian
- ☐ Native Hawaiian or other Pacific Island

Ethnicity:
- ☐ Hispanic
- ☐ Not Hispanic

Language:

Pharmacy and Address:

Emergency Contact and Relationship:

Email Address:

******WE HAVE A NEW PATIENT PORTAL IF YOU WANT ACCESS TO IT, PLEASE PROVIDE AN EMAIL ADDRESS******

PLEASE PROVIDE YOUR INSURANCE CARD AND DRIVERS LICENSE SO WE CAN MAKE A COPY FOR YOUR FILE.

ASSIGNMENT and RELEASE: I certify that I, and/or my dependent(s) have insurance coverage with the above insurance company(ies) and assign directly to all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature of all insurance submissions.

The above named physician may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below. I hereby authorize said assignee to release all information necessary to secure the payment. I authorize Carlos Silva, M.D. P.A to download my medication history and Rx benefits into my account from a Rx clearinghouse.

Signed: ____Date: ___________________

Medication List

Medication	DOSAGE	FREQUENCY

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MEDICAL AND SOCIAL HISTORY

Reason for your visit today: ____

Are you allergic to any medications? ____

Reaction: ____

Are you allergic to anything else? ____

Reaction: ____

Tobacco use (Circle one): Currently Uses tobacco - Used tobacco in the past – Never used

How Much: ______________________ How Long: _____________________________

Alcohol Use (Circle one): Currently Drinks Alcohol – Drank alcohol in the past – Never used

What Kind: ______________ How Much: _____________ How Long: ______________

Do you have, use, or do any of the following (Circle each that applies):

Exercise - Wear seat belts – Pets - Glasses/Contacts – Dentures - Artificial Joints -
Heart valves/blood vessels - a special diet - recreational drugs - victim of domestic violence.

Are you sexually active? Please Circle: YES NO

If yes: Men Women Both

Any Disabilities or Handicaps: ____

Date last complete physical exam: ____

If over the age of 50, date of last colonoscopy________________ Where? __________________

Women: Are you pregnant? _____________ Ever Pregnant? ___________

Number of deliveries? ___________ Number of Miscarriages/abortions? _________

Men: Last prostate check: ________________

Have you been immunized for (please circle): Measles, Mumps, rubella, Hepatitis, Polio, Pneumonia, Flu, and Tetanus.

Do you have a Living Will or Do not Resuscitate (DNR)? ______ If so please provide a copy.

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MEDICAL AND SURGICAL HISTORY

Please List all past surgeries: ____

Please check all the ones you had or currently have:

- ☐ ASTHMA
- ☐ HAY FEVER
- ☐ EMPHYSEMA
- ☐ PNEUMONIA
- ☐ CANCER
- ☐ DIABETES
- ☐ HIGH BLOOD PRESSURE
- ☐ HEART DISEASE
- ☐ HEART MURMUR
- ☐ HIGH BLOOD CHOLESTEROL
- ☐ RHEUMATIC FEVER
- ☐ THYROID DISEASE
- ☐ STROKE
- ☐ EPILEPTIC SEIZURE
- ☐ HEADACHES
- ☐ DEPRESSION
- ☐ NERVOUS BREAKDOWN
- ☐ ARTHRITIS
- ☐ GOUT
- ☐ VENEREAL DISEASE
- ☐ TUBERCULOSIS
- ☐ LIVER DISEASE
- ☐ JAUNDICE/HEPATITIS
- ☐ BLOOD TRANSFUSION
- ☐ ANEMIA
- ☐ BLEEDING TROUBLE
- ☐ STOMACH ULCERS
- ☐ HEARTBURN
- ☐ BOWEL OR COLON DISEASE
- ☐ SKIN DISEASE
- ☐ CATARACTS
- ☐ GLAUCOMA
- ☐ KIDNEY DISEASE
- ☐ URINE INFECTIONS
- ☐ PROSTATE PROBLEMS
- ☐ MENSTRUAL PROBLEMS
- ☐ SERIOUS INJURIES
- ☐ MEASLES
- ☐ RUBELLA
- ☐ MUMPS
- ☐ CHICKENPOX
- ☐ OTHER_____________

Please check and indicate relationship if any immediate family member has/had any of the following:

- ☐ ASTHMA
- ☐ HAY FEVER
- ☐ EMPHYSEMA
- ☐ PNEUMONIA
- ☐ CANCER
- ☐ DIABETES
- ☐ HIGH BLOOD PRESSURE
- ☐ HEART DISEASE
- ☐ HEART MURMUR
- ☐ HIGH BLOOD CHOLESTEROL
- ☐ RHEUMATIC FEVER
- ☐ THYROID DISEASE
- ☐ STROKE
- ☐ EPILEPTIC SEIZURE
- ☐ HEADACHES
- ☐ DEPRESSION
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- ☐ URINE INFECTIONS
- ☐ PROSTATE PROBLEMS
- ☐ MENSTRUAL PROBLEMS
- ☐ SERIOUS INJURIES
- ☐ MEASLES
- ☐ RUBELLA
- ☐ MUMPS
- ☐ CHICKENPOX
- ☐ OTHER_____________