FLORIDA SPECIALTY MEDICAL SERVICES LLC

MEDICAL HISTORY

Patient______________________________ Date______________

Reason for today's visit______________________________

Do you have now, or have you ever had diseases or conditions of: *(if yes, please check box)*

Lungs

☐ Bronchitis ☐ Emphysema ☐ Asthma ☐ Chronic Cough ☐ Morning Cough

Vascular

☐ High Blood Pressure ☐ Chest Pain ☐ Heart Attack ☐ Heart Murmur ☐ Irregular Heartbeat
☐ Pacemaker ☐ Blood Clot/Phlebitis ☐ Mitrel Valve Prolapse

Other Systemic

☐ Diabetes ☐ Thyroid ☐ Kidney ☐ Bladder ☐ Stomach
☐ Bowel ☐ Hepatitis A/B/C ☐ Glaucoma ☐ Arthritis/Joint

Current Medication **Y N** If yes,

Do you have any allergies to food or medicine? ☐ ☐ If yes, please list ______________________________

Do you currently use any prophylactic antibiotics? ☐ ☐ If yes, please list ______________________________

Do you currently drink alcohol? ☐ ☐ If yes, what ______________ |Amt per day: ______________

Do you currently use IV drugs? ☐ ☐ If yes, what ______________ |Amt per day: ______________

Do you currently take any medication? ☐ ☐ If yes, please list ______________________________

Have you ever been exposed to HIV/AIDS? ☐ ☐ Have you ever had a blood transfusion? Y ☐ N ☐
Ever had a dental anesthesia (Novacaine)? ☐ ☐ Any Adverse Reaction? Y ☐ N ☐
Are you latex intolerant? ☐ ☐

Skin Y N If yes,

Have you ever had skin cancer? ☐ ☐ Location(s) ______________________________
Family history of skin cancer? ☐ ☐ Relationship(s) ______________________________
Do you currently use skin care products? ☐ ☐ (What) ______________________________
When exposed to the sun, do you: Burn ☐ Tan ☐ Tan & Burn ☐
List any other disease or condition we should be aware of: List surgical procedures performed within the last 6 months:______________________________
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Please answer the following questions: Y N

A. Do you smoke? ☐ ☐
C. (Women) Are you pregnant? ☐ ☐
If no, date of last menstrual period:

Y N

B. Do you bleed easily? ☐ ☐
D. Do you have artificial joints, pins or screws? ☐ ☐
E. Do you require antibiotics prior to surgery? ☐ ☐

F. What is your occupation? ______________________

Completed by: Patient ☐__________________(initial)
Nurse ☐ __________________(initial)
M.A. ☐ __________________(initial)

Signed by Provider:______________________ Date
Reviewed by: ______________________ Date

Preferred Pharmacy:______________________________

Location:______________________ Pharmacy Phone Number:______________________