Flagler Family Medicine, P.A.

Please check the appropriate box if you or any of your blood relatives have ever had any of the listed conditions:

CONDITION	YOU	RELATIVE	CONDITION	YOU	RELATIVE
DIABETES			ANEMIA		
HIGH BLOOD PRESSURE			LEUKEMIA		
STROKE			SICKLE CELL		
HEART ATTACK			BLEEDING PROBLEMS		
ASTHMA			STOMACH ULCER		
MIGRAINE HEADACHES			GALLSTONES		
CANCER			SEIZURES		
EMPHYSEMA			TUBERCULOSIS		
KIDNEY PROBLEMS			ALCOHOLISM		
ARTHRITIS			SUICIDE		
GLAUCOMA / EYE PROBLEMS			DEPRESSION		
SKIN RASH			MENTAL ILLNESS		
OTHER			OTHER		

OPERATIONS / SURGERIES: ____________________

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Last Colonoscopy:____________________

OTHER HOSPITALIZATIONS: ____________________

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BLOOD TRANSFUSIONS: ____________________

MEDICATIONS: ____________ ____________ ____________

____________ ____________ ____________

____________ ____________ ____________

Last Pneumonia Vaccine(Pneumovax or Prevnar):____________________

Last Flu Vaccine:____________________

ALLERGIES: (Any reaction to any medication of any kind?) ____________________

OCCUPATION / WORK HISTORY: ____________________

Any exposure to pesticides, chemicals, or other hazards? YES ______ NO ______

If yes, What kind? ____________________

Family / Household: (Who lives at home with you?)____________________

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HABITS: Cigarettes: _________ PPD ____ X ________ years Quit in ____________ (year)

Other Tobacco Products? ____________________ Alcohol ____________________

Drug Use ____________________ Caffeine (coffee/colas)____________________

Seat Belt Use: Yes: _____ No _____ Exercise: ____________________

Age of first menstrual period ____________________ How many days between periods? ____________________

How many days does it last? ____________________ Is bleeding heavy or light? ____________________

Date of last menstrual period ____________________ Was it normal? ____________________

If menstrual periods have stopped, have you had any bleeding since? ____________________

Any Vaginal Discharge? Yes ________ No ________

Method of Preventing Pregnancy ____________________

Pregnancies ____________________ Births ______________ Abortions/Miscarriages ____________________

Last Mammogram:____________________Last Bone Density:____________________

Last Pap Smear: ____________________

Any other concerns? ____________________

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Name: ____________________

Social Security: ____________________

Birth Date: ____________________