# Shands Medical Group at Magnolia Parke

## Patient Data Base

Patient Name: MR#:

Today's date ________________ Age ____________ Home phone ________________________________

Date of birth ________________________________ Business phone ________________________________

Information about your health is needed by your doctor to understand your medical problems and to get to know you a little better as a person. This information will remain confidential *(private)* and will be available to your doctor only.

**Hospitalizations and Surgeries**

List the year, name of the hospital, and the location by city and state, where you were hospitalized or had any surgical procedures done. Include procedures like tonsillectomy/adenoidectomy, appendectomy, gallbladder removal, hemorrhoid removal, hysterectomy ***(uterus or womb removal),*** and D&C ***(dilatation and curettage).***

| | Year | Hospital/City and State | Reason for hospitalization or type of surgery performed |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |
| 6. | | | |
| 7. | | | |
| 8. | | | |

**Medications**

List any medicines that you use often or every day. Under ***dosage,*** list how much you are taking in either milligrams ***(mg)*** or number of pills per dose. Under ***how often,*** list how many times a day you take the medicine. Be sure to include medicines like tylenol, aspirin, antacids, laxatives, sleeping pills, cold medicines, antibiotics ***(penicillin, sulfa, etc.),*** codeine, diet pills, vitamins, sedatives ***(nerve pills),*** and birth control pills.

| | Medication | Dosage | How often |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |
| 6. | | | |
| 7. | | | |
| 8. | | | |
| 9. | | | |
| 10. | | | |

**Allergies**

List any medicine, food, plants, animals, or other products that you are allergic to.

## Review of Systems *(please check (✔) the box next to any illnesses or problems that apply to you)*

### I. General
- ☐ change in weight *(recent)*
- ☐ change in appetite *(recent)*
- ☐ weakness or fatigue *(recent)*
- ☐ bad nerves or tension
- ☐ crying for no reason
- ☐ depression
- ☐ poor memory
- ☐ suicidal

### Skin
- ☐ eczema
- ☐ hives/rashes
- ☐ acne
- ☐ skin cancer
- ☐ change in mole size

### Head and Nervous System
- ☐ migraine or severe headaches
- ☐ stroke
- ☐ seizures/epilepsy/convulsions
- ☐ polio
- ☐ nervous or emotional problems
- ☐ concussion
- ☐ meningitis
- ☐ loss of consciousness or blackouts
- ☐ dizziness
- ☐ numbness, tingling, or burning in hands or feet

### Ears
- ☐ deafness or trouble hearing
- ☐ ringing in ears
- ☐ chronic infections

### Eyes
- ☐ change in eyesight
- ☐ glaucoma
- ☐ cataracts
- ☐ blindness

### Glands
- ☐ thyroid disease
- ☐ goiter
- ☐ sugar diabetes
- ☐ obesity

### Lungs
- ☐ asthma
- ☐ emphysema
- ☐ pneumonia
- ☐ tuberculosis (TB)
- ☐ pleurisy
- ☐ bronchitis
- ☐ hay fever
- ☐ nagging cough
- ☐ coughing up blood

### Heart
- ☐ angina *(heart pains)*
- ☐ high blood pressure
- ☐ heart attack
- ☐ heart failure *(enlarged heart)*
- ☐ rheumatic fever
- ☐ chest pain
- ☐ racing heart or palpitations
- ☐ shortness of breath with work or exertion

### Blood Vessels
- ☐ varicose veins
- ☐ blood clots in leg *(phlebitis)*
- ☐ blood clots in lung
- ☐ leg pain with work or exertion
- ☐ swelling in feet or ankles

### Bones and Joints
- ☐ arthritis or rheumatism
- ☐ gout
- ☐ broken bones *(which ones?)* ______________________________
- ☐ scoliosis

### Abdomen
- ☐ ulcer or stomach bleeds
- ☐ hepatitis *(yellow jaundice)*
- ☐ cirrhosis
- ☐ pancreatitis
- ☐ gallstones
- ☐ gallbladder infection
- ☐ polyps in colon
- ☐ hemorrhoids
- ☐ hernias
- ☐ diverticulosis
- ☐ trouble swallowing
- ☐ constipation
- ☐ black, tarry, or bloody stools

### Kidney
- ☐ kidney stones
- ☐ kidney or bladder infection
- ☐ other kidney disease
- ☐ unable to control urination
- ☐ frequent urination

### Blood
- ☐ high cholesterol
- ☐ anemia
- ☐ bleeding problems
- ☐ blood transfusion
- ☐ sickle cell disease or trait

### Infections
- ☐ chicken pox
- ☐ mononucleosis

### Other
- ☐ cancer-type ____________________
- ☐ hoarseness *(recent)*
- ☐ other diseases ______________________________ ______________________________

### II. For Males Only
- ☐ enlarged prostate
- ☐ difficulty starting or stopping urine flow
- ☐ infection in prostate
- ☐ painful or lumpy testicles
- ☐ premature ejaculation
- ☐ venereal disease (VD)
- ☐ unable to obtain erection
- ☐ decreased interest in sex

Do you perform testes self-examination? ☐ Yes ☐ No

### III. For Females Only *(please check (✔) appropriate box or fill in blank)*

How old were you when periods first started? ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ 13 ☐ 14 ☐ 15 ☐ 16 ☐ 17 ☐ 18 years

How often are the periods? approximately every ☐ 3 weeks ☐ 4 weeks ☐ 5 weeks ☐ Other ____________________

How many days do the periods last? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ more than 7

Have you had menopause *(Change of life)?* ☐ Yes ☐ No If Yes, what year? ____________________

Do you use contraception? ☐ Yes ☐ No If Yes, what type? ____________________

Do you perform breast self-examination? ☐ Yes ☐ No

Date of last menstrual period ____________________

Have you had venereal or pelvic infections? ☐ Yes ☐ No

Last PAP smear: Date __________ Doctor's name ____________________ Results ____________________

Number of pregnancies __________ Number of living children __________

Number of abortions __________ Number of miscarriages __________

- ☐ discharge from nipples
- ☐ pain with intercourse
- ☐ lumps in breast
- ☐ unexpected vaginal bleeding
- ☐ decreased interest in sex
- ☐ bleeding after intercourse

## X-Rays/Immunizations/Other Tests

List the year that any of the following were performed.

| X-Ray | Year |
|---|---|
| Chest | ________ |
| Breast *(mammography)* | ________ |
| Stomach *(upperGI)* | ________ |
| Gallbladder | ________ |
| Colon *(Barium Enema)* | ________ |
| Kidney *(IVP)* | ________ |
| Back | ________ |
| Other ______________ | ________ |
| Other ______________ | ________ |
| Bone density | ________ |

| Immunizations/Other Tests | Year |
|---|---|
| EKG *(heart tracing or cardiogram)* | ________ |
| Prostate Specific Antigens | ________ |
| Sigmoidoscopy | ________ |
| Tetanus vaccination | ________ |
| Pneumococcal vaccination | ________ |
| Flu vaccination | ________ |
| Rubella vaccination | ________ |
| Hepatitis vaccination | ________ |
| Tuberculosis skin test | ________ |
| Vision test *(eye exam)* | ________ |
| Hearing test | ________ |
| Urinalysis *(urine test)* | ________ |
| Dental check-up | ________ |

If under 18, do you have an immunization record? ☐ Yes ☐ No

## Family History

Answer or check mark (✔) the appropriate item listed across the top row for each respective relative. Under brothers, sisters, and grandparents list only ***blood*** relationships.

| Family Member | Age | If deceased, age and cause of death | Cancer (type) | Diabetes | Kidney disease | Heart disease | Heart attack | Stroke | High blood pressure | Arthritis | Gout | Seizures/Epilepsy | Bleeding problems | Anemia | Sickle cell problems | Asthma/Allergies | Tuberculosis | Alcoholism | Nervous problems | Mental illness | Glaucoma | Migraines | Other | Other | Other | Other |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Father | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Mother | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Brothers and Sisters | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Other blood relatives with medical problems (grandparents, aunts, uncles, etc) | | | | | | | | | | | | | | | | | | | | | | | | | | |

## Remarks

______________________________________________

______________________________________________

______________________________________________

______________________________________________

______________________________________________

Please list all health care providers and their specialty *(eg, Dr. Jones – Neurology)*.

______________________ ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

***Please turn the page***

**Social/Lifestyle History**

Please answer the following questions. ***(where indicated, check (✔) appropriate response)***

1. Are you? ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Partner
2. Who lives in your house? ______________________________
3. Are there any members in the household who are disabled, or bedridden? ☐ Yes ☐ No

   If Yes, who? ______________________________
4. Are there many stresses at home? ☐ Yes ☐ No At work? ☐ Yes ☐ No
5. **Tobacco use** ***(check those tobacco products that you have ever used regularly)***

   ☐ Cigarettes ☐ Pipe ☐ Cigars ☐ Chewing tobacco ☐ Snuff ☐ None

   What is the average number of packs of cigarettes that you smoke or used to smoke per day?

   ☐ None ☐ less than $^{1}/_{2}$ ☐ $^{1}/_{2}$ – 1 ☐ 1 – 2 ☐ 2 or more

   How many years have you smoked? ☐ 0 ☐ 5 ☐ 10 ☐ 15 ☐ 20 ☐ 25 ☐ 30 ☐ 35 ☐ 40 ☐ more than 40

   Do you still smoke? ☐ Yes ☐ No If you have permanently quit, when? ______________________________
6. **Alcohol use**

   Have you ever had a problem with drinking alcohol? ☐ Yes ☐ No

   Has anyone close to you ever thought you drank too much? ☐ Yes ☐ No

   How often do you or did you drink beer, wine, or whiskey?

   ☐ Never ☐ Rarely ☐ Once a week ☐ Several times a week ☐ Daily

   Number of 12 ounce cans of beer consumed a week ______________________________

   Number of 8 ounce glasses of wine consumed a week ______________________________

   Number of shots (shot = 1$^{1}/_{2}$ ounces) of liquor consumed per week ______________________________

   Do you still drink? ☐ Yes ☐ No If you have permanently quit, when? ______________________________
7. Do you sometimes use marijuana or other drugs socially? ☐ Yes ☐ No
8. How many cups of coffee, tea, or cola do you drink per day? ☐ None ☐ 1 – 2 ☐ 3 – 6 ☐ 7 or more
9. Are you on a special diet? ☐ Yes ☐ No If Yes, what kind? ______________________________
10. How often do you exercise? ☐ Never ☐ Rarely ☐ Once a week ☐ Several times a week ☐ Daily

    What kind of exercises ______________________________
11. Do you have difficulty falling asleep or awakening early? ☐ Yes ☐ No ☐ Sometimes
12. What kind of work do you do? ______________________________

    Are you working now? ☐ Yes ☐ No

    Which of the following are you exposed to at work ☐ Excessive noise ☐ Fumes ☐ Air pollution

    ☐ Poisons and Chemicals ☐ Crowded conditions
13. Do you have a Living Will? ☐ Yes ☐ No
14. You are not required to answer the following questions, however, the answers may help your doctor give you better advice and treatment.

    A. Do you find your sexual life to be satisfactory? ☐ Yes ☐ No ☐ Sometimes

    What is your sexual preference? ☐ Heterosexual ***(opposite sex only)*** ☐ Homosexual ☐ Bisexual

    Do you have more than one sexual partner per year? ☐ Yes ☐ No

    B. Do you have a specific religion? ☐ Yes ______________ ☐ No

    C. Did/do you use *alternative* health providers/treatments, such as: accupunture, natural remedies (Chinese herbs), or homeopathy? ☐ Yes ☐ No If Yes, explain ______________________________

Reviewed

______________________________

______________________________ Patient Signature

______________________________