Family Practice of West Volusia, P.A.
BRUCE G. RANKIN, D.O. • MARY THERESA IZZO, ARNP, PH.D. • DEBORAH DARNELL, ARNP
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MEDICAL HISTORY

Today's Date: _____ Phone: Home_____ Work_____

Name: _____ Address:_____

Age:_____ Date of Birth:_____ Sex: M F _____ City:_____ State:_____ Zip:_____

SS # _____ Birth Place:_____ Occupation: _____

Race: _____

Please circle No or Yes. Have you ever:

Been refused employment for health reasons.....No ....Yes
Received Disability Compensation.....No ....Yes
Been refused life insurance for health reasons.....No ....Yes
Received Military Pension for medical reasons .....No ....Yes
Been Hospitalized .....No ....Yes
Injured on the Job .....No ....Yes
Workers Compensation .....No ....Yes
General Physical .....No ....Yes
Present Medical Insurance: _____

Date last seen by a doctor: _____ Doctor's Name: _____

Person to contact in the event of an emergency: Name: _____

Phone # _____ Address _____

	IF LIVING		IF DECEASED	
FAMILY HISTORY NAMES	AGE	HEALTH	AGE	CAUSE
Mother				
Father				
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Grandfather				
Brothers/Sisters				
Children				

PERSONAL HISTORY

HABITS: Do you:

Work regularly.....No ....Yes
If Yes, how many hours per week_____
Sleep well .....No ....Yes
Eat a regular diet .....No ....Yes
Eat a special diet .....No ....Yes
If Yes, what _____
Use alcoholic beverages .....No ....Yes
If Yes, what and how much_____
How often _____
Smoke .....No ....Yes
If Yes, what and how much_____
How many years _____
Have you EVER smoked.....No ....Yes
If yes, when did you quit _____
Drink coffee regularly .....No ....Yes
How many cups per day _____

WEIGHT

Now_____ lbs. 1 year ago _____ lbs.
Maximum weight _____ lbs.
When _____
Exercise daily .....No ....Yes

HEIGHT _____

LIST ALLERGIES: _____

LIST CURRENT MEDICATIONS (including over the counter): _____

LIST ILLNESSES AND DATES:_____

LIST HOSPITALIZATIONS AND DATES: _____

LIST SURGERIES AND DATES: _____

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FAMILY HISTORY

When completing the following, whenever you answer YES, fill in the relationship and approximate age.

EXAMPLE: *Asthma ..... Yes* *Sister* *4*

Has any blood relative ever had: (Circle No or Yes)	WHO	AGE
Cancer (including Leukemia).....No ....Yes	_____	_____
Tuberculosis .....No ....Yes	_____	_____
Diabetes .....No ....Yes	_____	_____
Heart Failure.....No ....Yes	_____	_____
Heart Attack .....No ....Yes	_____	_____
High Blood Pressure .....No ....Yes	_____	_____
Stroke .....No ....Yes	_____	_____
Epilepsy .....No ....Yes	_____	_____
Bleeding Disorder .....No ....Yes	_____	_____
Asthma .....No ....Yes	_____	_____
Liver Disease .....No ....Yes	_____	_____
Migraine Headaches.....No ....Yes	_____	_____
Alcoholism .....No ....Yes	_____	_____
Emphysema .....No ....Yes	_____	_____
Stomach or Duodenal Ulcer.....No ....Yes	_____	_____
Kidney Disease.....No ....Yes	_____	_____
Glaucoma .....No ....Yes	_____	_____
Sickle Cell Anemia.....No ....Yes	_____	_____
AIDS .....No ....Yes	_____	_____

PAST HISTORY - ILLNESS: Have you ever had:

	WHEN
Chicken Pox .....No.....Yes	_____
Gonorrhea or Syphilis.....No.....Yes	_____
Malaria .....No.....Yes	_____
Tuberculosis .....No.....Yes	_____
Cancer .....No.....Yes	_____
Herpes .....No.....Yes	_____
High Blood Pressure.....No.....Yes	_____
Diabetes.....No.....Yes	_____
Anesthesia problems? .....No.....Yes	_____
Have you ever been advised to have an operation which was not done? .....No.....Yes	_____

Why wasn't it done? _____

NERVOUS & MENTAL (NEURO): Have you ever had:

	WHEN
Frequent or severe headaches .....No.....Yes	_____
Loss of consciousness.....No.....Yes	_____
Dizzy or fainting spells.....No.....Yes	_____
Convulsions or paralysis.....No.....Yes	_____
Depression.....No.....Yes	_____
Psychiatric admission .....No.....Yes	_____
Nervous breakdown .....No.....Yes	_____
Epilepsy/Seizures.....No ....Yes	_____
Head Trauma .....No ....Yes	_____

EYES, EARS, NOSE AND THROAT - DO YOU

WHEN

Wear glasses .....No .....Yes Date of last exam _____

Have full dentures .....No .....Yes Partial dentures .....No .....Yes

Date of last dental exam _____

Are your teeth in good repair?.....No ....Yes	
Do you use a hearing aid? .....No ....Yes	
Have you ever had a detached retina? .....No ....Yes	_____
Do you have Glaucoma? .....No ....Yes	_____

CARDIO AND PERIPHERAL VASCULAR:

Have you ever had:	WHEN
Rheumatic fever or heart disease.....No ....Yes	_____
High blood pressure.....No ....Yes	_____
Heart murmur.....No ....Yes	_____
Chest pain or angina .....No ....Yes	_____
Palpitation or fluttering heart.....No ....Yes	_____
Swelling of feet or ankles .....No ....Yes	_____
Shortness of breath on exertion .....No ....Yes	_____
Have you ever been anemic .....No ....Yes	_____
Have you ever had a blood transfusion .....No ....Yes	_____
Do you have a pacemaker .....No ....Yes	_____

RESPIRATORY: Have you ever had:

	WHEN
Pneumonia or Pleurisy.....No ....Yes	_____
Hay fever .....No ....Yes	_____
Asthma .....No ....Yes	_____
Night sweats.....No ....Yes	_____
Spit up blood .....No ....Yes	_____
Shortness of breath .....No ....Yes	_____

GASTROINTESTINAL: Have you ever had:

	WHEN
Stomach trouble or ulcers .....No ....Yes	_____
Vomiting of blood .....No ....Yes	_____
Indigestion or heartburn.....No ....Yes	_____
Liver or Gallbladder disease .....No ....Yes	_____
Colitis or bowel disease.....No ....Yes	_____
Constipation .....No ....Yes	_____
Take laxatives frequently .....No ....Yes	_____
Recent change in bowel action .....No ....Yes	_____
Recent prolonged diarrhea.....No ....Yes	_____
Recent change in appetite/eating habits .....No ....Yes	_____
Hemorrhoids or rectal bleeding .....No ....Yes	_____
Black bowel movements .....No ....Yes	_____
Have you ever had a hernia? .....No ....Yes	_____

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MUSCULOSKELETAL:

Do you have or have you ever had:			WHEN
Arthritis	No	Yes	_____
Sciatica or low back pain	No	Yes	_____
Polio or Meningitis	No	Yes	_____
Fractures (broken bones)	No	Yes	_____

Where _____

Can you care for all your own needs?	No	Yes	_____

If no, why _____

Are you able to walk without assistance?	No	Yes	_____

If no, why?_____

How far? _____

Do you have difficulty going up stairs?	No	Yes	_____
Can you prepare your own meals?	No	Yes	_____

GENITOURINARY: Have you ever had:

			WHEN
Kidney disease or stones	No	Yes	_____
Venereal disease	No	Yes	_____
Difficulty in urination	No	Yes	_____
Frequent urination	No	Yes	_____
Burning or pain with urination	No	Yes	_____
Leakage of urine	No	Yes	_____
Blood in urine	No	Yes	_____

Number or times you arise to urinate during sleep hours _____

ENDOCRINE:

Have you ever had problems with:			WHEN
Thyroid	No	Yes	_____
Diabetes	No	Yes	_____
Extreme thirst	No	Yes	_____

SKIN: Have you ever had:

			WHEN
Skin diseases	No	Yes	_____

GYNECOLOGICAL (Women only):

Menstrual history - age of onset_____

Cycle _____ (days from start to start)

Usual duration _____ days

Regular _____ Irregular _____

First day of your last period _____ (date)

Birth control method _____

Date of last PAP (Cancer test) _____

Date of last breast exam _____

Date of last mammogram _____

Are you pregnant at this time?	No	Yes

No. of live births _____ No. of still births _____

No. of premature births _____ No. of miscarriages _____

No. of Cesarean Sections _____

Diabetes during pregnancy	No	Yes
Complications	No	Yes

IMMUNIZATIONS - CHILDHOOD & ADULT

Are you immunized against:			DATE
Hepatitis B	No	Yes	_____
MMR (Measles, Mumps, Rubella)	No	Yes	_____
Tetanus	No	Yes	_____
Pneumovax	No	Yes	_____
Influenza	No	Yes	_____

Date of last TB skin test _____

Results (If known) Positive _____ Negative _____

Date of last chest x-ray _____

Was it normal	No	Yes	_____

HAVE YOU HAD THE FOLLOWING:			DATE
Electrocardiogram (EKG)	No	Yes	_____
Stomach x-ray	No	Yes	_____
Kidney x-ray	No	Yes	_____
Bowel x-ray	No	Yes	_____

Of what _____

Nuclear scan	No	Yes	_____

Of what _____

X-ray/Radiation treatments	No	Yes	_____

For what _____

Electroencephalogram (EEG)	No	Yes	_____

For what _____

Other _____

Do you have someone locally who can help you if needed?	No	Yes
Are you able to be involved with social functions?	No	Yes

If not, why?_____

Are there cultural issues that affect your health care?	No	Yes

If yes, please explain _____

Are there medical treatment limitations based on your faith?	No	Yes
Will you accept blood transfusions?	No	Yes

How do you view your health?___ Poor ___ Fair ___Good ___Excellent

ADVANCED DIRECTIVES: Living Will: Yes or No Health Care Surrogate: Yes or No

I certify that all the information provided on this form is complete and accurate. _____
Signature Date

– NOTE: THIS RECORD IS CONFIDENTIAL