AMD PRIMARY CARE

1202 Kingsley Ave. Orange Park, FL 32073

(904) 579-4766 Fax: (877) 842-4020

Last Name: _____ First Name: _____ M.I ____

DOB: _____ Age: _____ Sex: _____ SS#_____

Patient Address: _____

City: _____ State: _____ Zip: _____

Primary # (Cell/work/home): _____ Email: _____

Secondary # (Cell/work/home): _____ Employer: _____

Marital Status (please check one): __Single __ Married __Divorced __Widow

Race: __White __Black __Asian __Hispanic __ American Indian __Other

Reason For Visit: _____
Patient bring: EKGs X-Rays Notes Other: _____
Who Referred You Here/ How Did You Hear About Us? _____

Emergency Contact(s) and Person(s) you permit to obtain Medical Records and Prescriptions on your behalf.

Contact Name: _____ Relationship: _____ Phone#_____
Contact Name: _____ Relationship: _____ Phone#_____
Contact Name: _____ Relationship: _____ Phone#_____

***Primary Insurance Coverage: _____**

Policy Holder's Name: _____ DOB: _____

Policy Holder's SSN: _____ Sex: __ Male __ Female

Your Relationship to the policy holder: _____

ID #: _____ Group # _____

Secondary Insurance Coverage: _____

Policy Holder's Name: _____ DOB: _____

Your Relationship to the policy holder: _____ ID #: _____

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Patient Name: _____ Date: _____

* Please list all previous surgical procedures and dates (month and year): None ☐

_____ _____ _____

_____ _____ _____

KNOWN DRUG/NON-DRUG ALLERGIES and REACTIONS: (Iodine, Shellfish and/or IV contrast, Adhesives, Latex, Penicillin)

_____ _____

_____ _____

Preventive Health: Last Colonoscopy date: _____ Last Mammogram date: _____

PHARMACY INFORMATION

Name: _____ Phone #: _____

Location: _____

*** Please List all current medications and dose if known, including any vitamins or herbal remedies.**

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

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* FAMILY HISTORY:

Member	Age	State of Health	Significant Current Problems or Causes of Death
♂ Father	___	_____	_____
♀ Mother	___	_____	_____
♂ Brother	___	_____	_____
♀ Sister	___	_____	_____

* SOCIAL HISTORY:

Blood Transfusions: (Please check one): I will accept blood products in an emergency _____ Yes _____ No

Have you ever had a transfusion reaction? _____ Yes _____ No

What is your highest education? ❑High school ❑Some college ❑College graduate ❑Advanced degree

What is/was your occupation? _____ ___ Retired Disabled. Reason _____

Dominant Hand: _____ Right Hand _____ Left Hand Approximate: Height _____ft. _____in. Weight_____lbs.

___ Current Tobacco User: ___ Former Tobacco User ___ Never Used Tobacco

Type: ___ Cigarettes /Cigars ___Smokeless Amount/day: _____ Years Used: _____ Quit Date: _____

___ Consume Alcohol: Type: _____ Amount/day: _____

___ Use recreational drugs: Type: _____ Amount/day: _____

___ Consume caffeine: Type: _____ Amount/day: _____

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PAST MEDICAL HISTORY

Do you now or have you ever had:

❑ Diabetes	❑ Heart murmur	❑ Crohn's disease
❑ High blood pressure	❑ Pneumonia	❑ Colitis
❑ High cholesterol	❑ Pulmonary embolism	❑ Anemia
❑ Hypothyroidism	❑ Asthma	❑ Jaundice
❑ Goiter	❑ Emphysema	❑ Hepatitis
❑ Cancer (type) _____	❑ Stroke	❑ Stomach or peptic ulcer
❑ Leukemia	❑ Epilepsy (seizures)	❑ Rheumatic fever
❑ Psoriasis	❑ Cataracts	❑ Tuberculosis
❑ Angina	❑ Kidney disease	❑ HIV/AIDS
❑ Heart problems	❑ Kidney stones	

Other medical conditions (please list):

_____

_____

_____

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SYSTEMS REVIEW

In the past month, have you had any of the following problems?

GENERAL

- ❑ Recent weight gain; how much____
- ❑ Recent weight loss: how much____
- ❑ Fatigue
- ❑ Weakness
- ❑ Fever
- ❑ Night sweats

MUSCLE/JOINTS/BONES

- ❑ Numbness
- ❑ Joint pain
- ❑ Muscle weakness
- ❑ Joint swelling

Where?

EARS

- ❑ Ringing in ears
- ❑ Loss of hearing

EYES

- ❑ Pain
- ❑ Redness
- ❑ Loss of vision
- ❑ Double or blurred vision
- ❑ Dryness

NERVOUS SYSTEM

- ❑ Headaches
- ❑ Dizziness
- ❑ Fainting or loss of consciousness
- ❑ Numbness or tingling
- ❑ Memory loss

STOMACH AND INTESTINES

- ❑ Nausea
- ❑ Heartburn
- ❑ Stomach pain
- ❑ Vomiting
- ❑ Yellow jaundice
- ❑ Increasing constipation
- ❑ Persistent diarrhea
- ❑ Blood in stools
- ❑ Black stools

SKIN

- ❑ Redness
- ❑ Rash
- ❑ Nodules/bumps
- ❑ Hair loss
- ❑ Color changes of hands or feet

PSYCHIATRIC

- ❑ Depression
- ❑ Excessive worries
- ❑ Difficulty falling asleep
- ❑ Difficulty staying asleep
- ❑ Difficulties with sexual arousal
- ❑ Poor appetite
- ❑ Food cravings
- ❑ Frequent crying
- ❑ Sensitivity
- ❑ Thoughts of suicide / attempts
- ❑ Stress
- ❑ Irritability
- ❑ Poor concentration
- ❑ Racing thoughts
- ❑ Hallucinations
- ❑ Rapid speech
- ❑ Guilty thoughts
- ❑ Paranoia
- ❑ Mood swings
- ❑ Anxiety
- ❑ Risky behavior

OTHER PROBLEMS:

THROAT

- ❑ Frequent sore throats
- ❑ Hoarseness
- ❑ Difficulty in swallowing
- ❑ Pain in jaw

HEART AND LUNGS

- ❑ Chest pain
- ❑ Palpitations
- ❑ Shortness of breath
- ❑ Fainting
- ❑ Swollen legs or feet
- ❑ Cough

BLOOD

- ❑ Anemia
- ❑ Clots

KIDNEY/URINE/BLADDER

- ❑ Frequent or painful urination
- ❑ Blood in urine

Women Only:

- ❑ Abnormal Pap smear
- ❑ Irregular periods
- ❑ Bleeding between periods
- ❑ PMS

WOMENS REPRODUCTIVE HISTORY:

Age of first period:

Pregnancies:

Miscarriages:

Abortions:

Have you reached menopause? Y / N At what age?

Do you have regular periods? Y / N

I certify that, to the best of my knowledge, the about information is complete and accurate.

Patient Name: _____

Signature: _____ **Date: _____**