Florida Health Care Plans
An Independent Licensee of the Blue Cross and Blue Shield Association

MEDICAL HISTORY FORM

Today's date: _____

Name: _____ Gender: ☐ Male ☐ Female

Ethnicity: ☐ Hispanic/Latino ☐ Other
Race: ☐ White ☐ Black ☐ Other ☐ Asian ☐ Hispanic ☐ North American Native

Insurance Name: _____ Insurance Card #: _____

Phone #: _____ Cell Phone #: _____
DOB: _____ e-mail Address: _____

Are you registered for Follow My Health? ☐ Yes ☐ No

What medical problems do you have? (Example: Diabetes, Hypertension, Congestive Heart Failure, Chronic Low Back Pain, Arthritis of the Right Knee, Cancer of the Breast). Please indicate **all** problems below:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____

What surgery have you had? What date was it done? (Example: Gallbladder removed by laparoscopy, Feb. 2004; Coronary artery bypass graft – 5 vessels, Summer 2006; Splenectomy, vaginal hysterectomy and both ovaries removed, 5/1/02; Abdominal hysterectomy and the right ovary removed, 1970).

SURGERY	DATE
1.	
2.	
3.	
4.	
5.	
6.	
7.	

Have you ever been admitted to the hospital? ☐ Yes ☐ No | If yes, where, date & reason:

WHERE	DATE	REASON
1.		
2.		
3.		
4.		
5.		
6.		

What medications do you take? Include all over-the-counter medications. (Example: Simvistatin 20 mg once a day, Enalapril 10 mg two times a day, Aspirin 81 mg once a day, Niacin 500 mg once a day, vitamin once a day)

MED	DOSE	HOW OFTEN	WHO PRESCRIBED
1. Example: Enalapril	10 mg	Two times a day	Dr. Smith
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			
17.			
18.			
19.			
20.			

What allergies do you have? What happens? (Example: Penicillin – shortness of breath, Sulfa – rash, Latex, rash).

ALLERGIES	REACTION
1.	
2.	
3.	
4.	
5.	

List all the Physicians you see. (Example: Dr. Wesley Driggers - Family Medicine, Dr. David Williams - Cardiology, Dr. Vinod Patel - Nephrology, Dr. Pamela Carbiener – OB/GYN).

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

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Name: _____

Please tell us about specific family members: ☐ Adopted – Family History Unknown
This will help us evaluate your future risk factors. Important diseases to include are Hypertension, Diabetes, Heart Disease, Kidney Disease, Types of Cancer, Bleeding Problems, Endocrine Problems, Neurologic Disease, Mental Health Diseases or Rheumatology Diseases like Lupus or Rheumatoid Arthritis.

Father: ☐ Living ☐ Deceased DOB: _____ or Age at death: _____
Medical problems: _____
Cause of death: _____
(Examples: Hypertension, Diabetes, cancer of the breast, cancer of the colon).

Mother: ☐ Living ☐ Deceased DOB: _____ or Age at death: _____
Medical problems: _____
Cause of death: _____

Paternal Grandfather: ☐ Living ☐ Deceased DOB: _____ or Age at death: _____
Medical problems: _____
Cause of death: _____

Paternal Grandmother: ☐ Living ☐ Deceased DOB: _____ or Age at death: _____
Medical problems: _____
Cause of death: _____

Maternal Grandfather: ☐ Living ☐ Deceased DOB: _____ or Age at death: _____
Medical problems: _____
Cause of death: _____

Maternal Grandmother: ☐ Living ☐ Deceased DOB: _____ or Age at death: _____
Medical problems: _____
Cause of death: _____

Brother #1: ☐ Living ☐ Deceased DOB: _____ or Age at death: _____
Medical problems: _____
Cause of death: _____

Brother #2: ☐ Living ☐ Deceased DOB: _____ or Age at death: _____
Medical problems: _____
Cause of death: _____

Brother #3: ☐ Living ☐ Deceased DOB: _____ or Age at death: _____
Medical problems: _____
Cause of death: _____

Sister #1: ☐ Living ☐ Deceased DOB: _____ or Age at death: _____
Medical problems: _____
Cause of death: _____

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Sister #2: ☐ Living ☐ Deceased DOB: _____ or Age at death: _____
Medical problems: _____
Cause of death: _____
Sister #3: ☐ Living ☐ Deceased DOB: _____ or Age at death: _____
Medical problems: _____
Cause of death: _____

Maternal Aunt #1 _____ Medical problems: _____

Maternal Aunt #2 _____ Medical problems: _____

Maternal Uncle #1 _____ Medical problems: _____

Maternal Uncle #2 _____ Medical problems: _____

Paternal Aunt #1 _____ Medical problems: _____

Paternal Aunt #2 _____ Medical problems: _____

Paternal Uncle #1 _____ Medical problems: _____

Paternal Uncle #2 _____ Medical problems: _____

Children _____ Medical problems: _____

Please tell us about yourself.

Current occupation: _____
☐ Retired ☐ Disabled ☐ Student ☐ Never worked
Marital status:
☐ Currently married
☐ Divorced _____ times
☐ Never married
☐ Separated
☐ Single
☐ Widowed

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Name: _____

EDUCATION

Highest level of education achieved: _____

☐ Currently in school Grade _____

☐ Doing well in school ☐ Having difficulty in school

☐ Not able to read ☐ Not able to write

TOBACCO

☐ Never smoked

Have you smoked at least 1 cigarette in the last 6 months? ☐ Yes ☐ No

Smoked _____ packs for _____ years

Quit smoking on _____
(Date)

ALCOHOL

☐ No alcohol in the last 12 months

☐ Recovering alcoholic

Drink _____ beers per week.

Drink _____ glasses of wine per week.

Drink _____ shots of liquor per week.

Have you ever felt you should cut down on your drinking? ☐ Yes ☐ No

Have people annoyed you by criticizing your drinking? ☐ Yes ☐ No

Have you felt guilty about your drinking? ☐ Yes ☐ No

Have you ever had a drink in the morning to steady your nerves or get rid of a hangover? ☐ Yes ☐ No

Have you had an accident or broken a bone due to drinking? ☐ Yes ☐ No

OTHER SUBSTANCES

☐ Use marijuana How often _____

☐ Use cocaine How often _____

☐ Use of street drugs – what _____ How often _____

BIRTH CONTROL METHOD

☐ Don't use birth control

☐ Trying to get pregnant

☐ Tubal ligation

☐ Vasectomy

☐ Birth control pills or patch

☐ IUD

☐ Injection

☐ Hysterectomy

☐ Abstaining

☐ Condoms

FEMALES:

Date of Last Pap Smear: _____

Have you ever had an abnormal pap? ☐ Yes ☐ No

Date of Last Mammogram: _____

Have you ever had a blood transfusion? ☐ Yes ☐ No

If yes, date of transfusion: _____

SEXUAL HISTORY

☐ Heterosexual ☐ Homosexual ☐ Bisexual

# of partners in the last year? _____

# of partners in your lifetime? _____

History of sexual abuse or rape? ☐ Yes ☐ No

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DIET

Do you eat at least 5 fruits or vegetables a day? ☐ Yes ☐ No
Have you had a weight change greater than 10 lbs in the last month? ☐ Yes ☐ No

EXERCISE

What exercise do you do?
(Example: Walk 1 mile 3 days a week, water aerobics 1 hour once a week, go to the gym and lift weights 30 minutes 3x/wk).

1. _____
2. _____
3. _____
4. _____

Do you have a caregiver? ☐ Yes ☐ No
If so, who is your caregiver: Name: _____
Phone: _____ Cell: _____
e-mail: _____
Caregiver on site: _____ days/week
Caregiver on site: _____ hours/day

What is your native language? _____
What other languages do you speak? _____

LIVING ARRANGEMENTS

☐ Private residence ☐ own ☐ rent
☐ Apartment
☐ Assisted Living
☐ Nursing Home
☐ Hospice

Number of people living with you _____

Do you drive? ☐ Yes ☐ No
Do you use a ☐ Cane ☐ Walker ☐ Wheelchair

Do you have an Advance Directive? ☐ Yes ☐ No
Would you like more information on Advance Directives? ☐ Yes ☐ No
Who is your Power of Attorney? _____

PREVENTIVE

Have you had a colonoscopy? ☐ Yes ☐ No
If yes, where? _____ Date: _____

Have you had a Bone Density? ☐ Yes ☐ No Date: _____

Did you have chicken pox disease? ☐ Yes ☐ No Date: _____

Have you had a Pneumonia shot? ☐ Yes ☐ No Date: _____

Have you had a Tetanus shot? ☐ Yes ☐ No Date: _____