THE MEDICAL GROUP
OF SOUTH FLORIDA, INC.

PATIENT INFORMATION

PATIENT INFORMATION

Name		Age	Date of Birth / /
Address		City/State	Zip
Secondary Address		City/State	Zip
Home Phone ( )	Cell Phone ( )	Email	
SS#	Emergency Contact Name & Relation		
Marital Status M S D W	Emergency Contact Number ( )		
Employment Status Full Time Part Time Retired Student	Employer		
Pharmacy Name & Location	Pharmacy Phone Number ( )		
Primary Care Physician	PCP Phone Number ( )		
What is the reason for your visit today?			

INSURANCE INFORMATION

☐ **Today's visit should be filed to my HEALTH INSURANCE – Please give your health insurance card to the receptionist**

Insurance Company Name	Policy #	Group #

☐ **Today's visit should be filed to WORKERS COMP INSURANCE – Please give the information to the receptionist**

Insurance Company Name	Policy #	Group #
Adjuster's Name	Phone ( )	Email

☐ **Today's Visit is related to an AUTO ACCIDENT– Please give the information to the receptionist**

PIP Insurance Name	Policy #
Adjuster's Name	Adjuster's Phone ( )
Attorney's Name	Attorney's Phone ( )
Date of Accident	Claim Number

☐ **Today's Visit is related to a SLIP & FALL– Please give the information to the receptionist**

PIP Insurance Name	Policy #
Adjuster's Name	Adjuster's Phone ( )
Attorney's Name	Attorney's Phone ( )
Date of Accident	Claim Number

THE MEDICAL GROUP
OF SOUTH FLORIDA, INC.

HEALTH HISTORY

ALL PATIENTS MUST COMPLETE THIS SECTION

CHIEF COMPLAINT

IMMUNIZATION RECORDS

Tetanus Shot Date / /			Number of Living Children	
Pneumonia Vaccine Date / /				
Flu Shot Date / /				
Any Cancers In	Children ☐ Yes ☐ No	Type of Cancer?		
	Parents ☐ Yes ☐ No	Type of Cancer?		
	First Degree Relatives ☐ Yes ☐ No	Type of Cancer?		
Height		Weight		
If You Are Male	Do you examine your testicles monthly? ☐ Yes ☐ No			
If You Are Female	Do you examine your breasts monthly? ☐ Yes ☐ No			
	Last Mammogram Date / /	Last PAP Date / /		
	Physician/Facility Performed By			
	Number of Pregnancies	Number of Live Births	Weight of Largest Baby at Birth lbs ounces	
	Is it possible you are pregnant? ☐ Yes ☐ No			

THE MEDICAL GROUP
OF SOUTH FLORIDA, INC.

HEALTH HISTORY

ALL PATIENTS MUST COMPLETE THIS SECTION

PLEASE CIRCLE ALL SYMPTOMS OR DIAGNOSIS YOU HAVE BELOW

Abdominal Pain	Blood in Stool	Dizziness	Irritable Colon	PMS	Disorder
ADD	Blood in Urine	Fainting	Joint Pain	Polio	STD
Allergies	Breast Cancer	Fever / Sweats	Kidney Disease	Problem Walking	Stroke / TIA
Alzheimer's	Breast Mass	Frequent Urination	Kidney Stones	Prostate Disease	Thyroid Problem
Angina	Bulimia	Headache	Liver Disease	Scoliosis	Ulcer
Anorexia	Cancer	Heart Attack	Lung Disease	Short of Breath	Vaginal Bleed After Menopause
Anxiety	Change in Vision	Heart Disease	Migraine	Sickle Cell Anemia	Seeing Pain Management
Arthritis	Chest Pain	High Blood Pressure	MS	Seizures	
Asthma	Cough	HIV / AIDS	Osteoporosis	Sinus Trouble	
Blood Disorder	Depression	Intestine Disorder	Panic Disorder	Spinal Disc	

List Any Other Medical Condition

List Any Medical Conditions That Run In Your Family

Do You Live With Someone Other Than Yourself

Patient Exercises ☐ Regularly ☐ Moderately ☐ Rarely ☐ Never | Use of Alcohol ☐ Regularly ☐ Moderately ☐ Rarely ☐ Never

Use of Tobacco ☐ Current, How Many Per Day ☐ Never ☐ Former | If Former, How Long Months Years

Allergies ☐ Dust ☐ Penicillin ☐ Pollen ☐ Sulfa Drugs ☐ Dander ☐ Dairy Products ☐ Latex ☐ Perfumes

☐ Secondary Smoke ☐ Eggs ☐ Contrast Dye ☐ Meds (list Below)

Other

PAST SURGICAL & HOSPITALIZATION HISTORY

Type of Surgery/Cause of Hospitalization		Date / /
Where	Surgeon	Complications
Type of Surgery/Cause of Hospitalization		Date /
Where	Surgeon	Complications

LIST ALL MEDICATIONS / SUPPLEMENTS YOU ARE TAKING

Are You Taking Nutritional Supplements? ☐ Yes ☐ No

If Yes, What Vitamin Supplements?

Are You Taking Prescription Medications? ☐ Yes ☐ No If YES, Please List Medications Below

Name/Dose	Name/Dose
Name/Dose	Name/Dose
Name/Dose	Name/Dose
Name/Dose	Name/Dose