FLORIDA INTEGRATIVE MEDICAL CENTER

2415 University Pkwy, Ste. 218, Sarasota, FL 34243 | (941) 955-6220

Patient Information Form

Date: _____

Legal Name: _____ **DOB:** _____

Preferred Name: _____ **Sex:** **F** **M**

Mailing Address: _____ **Unit#:** _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____

Email: _____ **Marital Status:** _____

Occupation: _____ **Employer:** _____

Known Allergies: _____

How did you hear about us? _____

Name of referral, if applicable: _____

Do you have any of the following advance directives in place? (please circle all that apply)

Living Will Healthcare Surrogate POA/DPOA DNR

Please provide copies of any advanced directives you have in place to be added to your chart.

Emergency Contact

Name: _____ **Relationship:** _____

Home Phone: _____ **Cell Phone:** _____

Insurance Information

Insurance Provider: _____ **Policy #:** _____

Claims Address: _____

Phone: _____

"I authorize the release of any medical information necessary for the processing of medical claims related to laboratory services. I understand that Florida Integrative Medical Center is a self-pay practice and does not bill or submit claims to insurance for office services. As a courtesy, certain routine laboratory services may be submitted to insurance; however, I acknowledge that I remain fully responsible for all charges incurred, including any amounts not covered or paid by my insurance or other third-party payers."

_____

SIGNATURE PRINT NAME DATE

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Patient Intake & Health History

- Please complete this patient intake and health history as thoroughly as possible.
- The form is used to learn about your unique healthcare needs.
- Print all information and mark anything you don't understand with a question mark.
- Fill out the Medications & Supplements page as complete as possible

When and where did you last receive medical or health care?

_____

_____

_____

What was the reason?

_____

_____

_____

What are your biggest health concerns/goals? Please list in order of importance.

1. _____

   _____

2. _____

   _____

3. _____

   _____

4. _____

   _____

5. _____

   _____

_____

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Review of Symptoms

For each of the following, please circle Y, P, or N.

Y = Current condition P = Past condition N = Never had

General Information			
Fatigue	Y	P	N
Current weight			
Maximum weight			
When?			
Height			
Skin			
Rashes	Y	P	N
Eczema	Y	P	N
Hives	Y	P	N
Acne	Y	P	N
Boils	Y	P	N
Itching	Y	P	N
Color change	Y	P	N
Lumps	Y	P	N
Night sweats	Y	P	N
Head			
Headache	Y	P	N
Head Injury	Y	P	N
When?			
Eyes			
Impaired vision	Y	P	N
Glasses/contacts	Y	P	N
Eye pain	Y	P	N
Tearing/dryness	Y	P	N
Double vision	Y	P	N
Glaucoma	Y	P	N
Cataracts	Y	P	N
Ears			
Impaired hearing	Y	P	N
Ringing	Y	P	N
Earache	Y	P	N
Dizziness	Y	P	N
Nose & Sinuses			
Frequent colds	Y	P	N
Nose bleeds	Y	P	N
Stuffiness	Y	P	N
Hay fever	Y	P	N
Sinus problems	Y	P	N
Drainage	Y	P	N

Mouth and Throat			
Frequent sore throat	Y	P	N
Sore tongue	Y	P	N
Gum problems	Y	P	N
Hoarseness	Y	P	N
Dental Cavities	Y	P	N
Neck			
Lumps	Y	P	N
Swollen glands	Y	P	N
Goiter	Y	P	N
Pain/stiffness	Y	P	N
Respiratory and Breathing			
Cough	Y	P	N
Sputum	Y	P	N
Spitting up blood	Y	P	N
Wheezing	Y	P	N
Asthma	Y	P	N
Bronchitis	Y	P	N
Pneumonia	Y	P	N
Pleurisy	Y	P	N
Difficulty breathing	Y	P	N
Painful breathing	Y	P	N
Shortness of breath	Y	P	N
S.O.B. at night	Y	P	N
S.O.B. lying down	Y	P	N
Tuberculosis	Y	P	N
Cardiovascular			
Heart disease	Y	P	N
Angina	Y	P	N
High blood pressure	Y	P	N
Murmurs	Y	P	N
Rheumatic fever	Y	P	N
Chest pain	Y	P	N
Swelling in ankles	Y	P	N
Palpitation, flutters	Y	P	N
Blood			
Anemia	Y	P	N
Easy bleeding or bruising	Y	P	N

Gastrointestinal (Digestion)			
Trouble swallowing	Y	P	N
Heartburn	Y	P	N
Change in thirst	Y	P	N
Change in appetite	Y	P	N
Nausea	Y	P	N
Vomiting	Y	P	N
Vomiting blood	Y	P	N
Belching/passing gas	Y	P	N
Jaundice (yellow skin)	Y	P	N
Liver disease	Y	P	N
Gall bladder disease	Y	P	N
Ulcer	Y	P	N
Hemorrhoids	Y	P	N
Bowel Movements:			
Frequency:			
Is this a change?			
Urinary			
Pain when urinating	Y	P	N
Increased frequency	Y	P	N
Frequency at night	Y	P	N
Inability to hold urine	Y	P	N
Frequent infections	Y	P	N
Kidney Stones	Y	P	N
Musculoskeletal			
Joint pain or stiffness	Y	P	N
Arthritis	Y	P	N
Broken bones	Y	P	N
Muscle spasms/cramp	Y	P	N
Weakness	Y	P	N
Peripheral Vascular			
Deep leg pain	Y	P	N
Cold hands/feet	Y	P	N
Varicose veins	Y	P	N
Thrombophlebitis	Y	P	N
Emotional			
Depression	Y	P	N
Mood swings	Y	P	N
Anxiety/nervousness	Y	P	N
Tension	Y	P	N

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Review of Symptoms – Continued

For each of the following, please circle Y, P, or N.

Y = Current condition P = Past condition N = Never had

Female Reproduction			
Age menses began			
Average # of days			
Length of cycle			
Spotting off-cycle	Y	P	N
Irregular cycle	Y	P	N
Pain during sex	Y	P	N
Painful menses	Y	P	N
Excessive flow	Y	P	N
Birth control	Y	P	N
What type?			
# of pregnancies			
# of live births			
# of miscarriages			
# of abortions			
Difficulty conceiving	Y	P	N
Menopause	Y	P	N
Sexually active	Y	P	N
Sexual difficulty	Y	P	N
Venereal disease	Y	P	N
Discharge or sores	Y	P	N

Breasts			
Do you self-exam?	Y		N
Lumps	Y	P	N
Pain (or tenderness)	Y	P	N
Nipple discharge	Y	P	N
Male Reproduction			
Hernias	Y	P	N
Testicular masses	Y	P	N
Testicular pain	Y	P	N
Sexually active	Y	P	N
Sexual difficulties	Y	P	N
Prostate disease	Y	P	N
Venereal disease	Y	P	N
Discharge or sores	Y	P	N

Neurological			
Fainting	Y	P	N
Seizures	Y	P	N
Paralysis	Y	P	N
Muscle weakness	Y	P	N
Numbness/tingling	Y	P	N
Memory loss	Y	P	N
Endocrine			
Hypothyroid	Y	P	N
Heat/cold intolerance	Y	P	N
Excessive thirst	Y	P	N
Excessive hunger	Y	P	N

Notes: _____

Do you eat three meals daily?	Y	N
Do you awaken feeling rested?	Y	N
Do you sleep well?	Y	N
Do you average 6-8 hours of sleep?	Y	N
Do you enjoy your work?	Y	N
Do you spend time outside?	Y	N
If yes, how often?		
Do you watch television?	Y	N
If yes, how many hours per day?		
Do you read?	Y	N
If yes, how many hours per day?		
Have you been treated for drug dependence?	Y	N
If yes, please explain what for, etc:		
Do you use recreational drugs?	Y	N
If yes, how often?		

Do you consume alcoholic beverages?	Y	N
If so, how often?		
Have you been treated for alcoholism?	Y	N
If so, when?		
Do you use tobacco?	Y	N
If so, how often? How many per day? For how long?		
Do you exercise?	Y	N
If yes, what type(s) of exercise? How often? How many minutes per day? Per week?		
Please list any relevant interests/hobbies:		

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Medication and Supplements

Please list any/all of the following:

- Prescription medications
- Vitamins & minerals
- Over-the-counter medications
- Herbs
- All other supplements

Name of Prescription or Supplement	Dose	Frequency	How long	Who started
EXAMPLE—Vitamin C	500 mg	1x/day	1 year	(MD or self)

** If more space is needed, please add on back of this sheet or add a second sheet **

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Family History

Please check any/all that apply unless otherwise directed.

	Father	Mother	Brother(s)	Sister(s)	Spouse	Child(ren)
Age (if living)						
Health (G = good | P = poor)						
Cancer						
Diabetes						
Heart disease						
High blood pressure						
Stroke						
Epilepsy						
Mental Illness						
Asthma, hayfever, hives						
Anemia						
Kidney disease						
Glaucoma						
Tuberculosis						
Age of death (if applicable)						
Cause of death (if applicable)						

For the following selections, please circle Y, yes, or N, no.

Childhood Illness History		
Scarlet Fever	Y	N
Mumps	Y	N
Diptheria	Y	N
Measles	Y	N
Rheumatic Fever	Y	N
German Measles	Y	N
Other:		

Immunization History		
Polio	Y	N
Tetanus (not antitoxin)	Y	N
Diptheria	Y	N
Measles	Y	N
Pertussis	Y	N
Other:		

Hospitalization and Surgery

Please list hospitalizations and surgeries you have had: _____

_____

_____

X-Rays and Special Studies

Please list any X-Rays, CT scans, MRIs, or other relevant imaging: _____

_____

_____

Electrocardiogram (EKG) Yes No Electroencephalogram (EEG) Yes No

_____

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