

**2700 Old Winter Garden Road**

**Ocoee, FL 34761**

**407-654-2724**

**Intake Form**

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| **Demographic Information** |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (LEGAL NAME) Date: \_\_\_\_\_\_\_ / \_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_\_ FIRST MIDDLE LAST Date of Birth: \_\_\_\_\_\_\_ / \_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_ Sex: [ ]  Male [ ]  FemaleRace: [ ]  White [ ]  Black or African American [ ]  Asian [ ]  American Indian or Alaska Native [ ]  Native Hawaiian or Other Pacific Islander [ ]  Other, Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Marital Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Highest Level of Education: \_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Patient Contact Information** |
| Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_What is the best time of Day to Contact You? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Emergency Contact** |
| Primary Emergency Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Secondary Emergency Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Primary Care Physician Information** |
| Primary Care Physician or Office Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Office Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |



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| **Tobacco History** |
| Have you ever Smoke Tobacco Products? [ ]  Yes [ ]  NoType of Tobacco Product(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_If Yes, Amount per Day: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ # of Years Smoked: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Are you still smoking? [ ]  Yes [ ]  No If no, when did you quit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Alcohol History** |
| Have you ever consumed alcohol? [ ]  Yes [ ]  NoType of Alcohol: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_If Yes, Amount Consumed per Day: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ # of Years Consumed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Are you still consuming alcohol? [ ]  Yes [ ]  No If no, when did you quit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Allergies****[ ]  None** |
| **Food/Drug Allergy** | **Start Date** | **Reaction** |
|  | [ ]  Birth or [ ]  Onset Date: \_\_\_\_\_\_\_\_\_ |  |
|  | [ ]  Birth or [ ]  Onset Date: \_\_\_\_\_\_\_\_\_ |  |
|  | [ ]  Birth or [ ]  Onset Date: \_\_\_\_\_\_\_\_\_ |  |
|  | [ ]  Birth or [ ]  Onset Date: \_\_\_\_\_\_\_\_\_ |  |
| **Family History** |
| **Diagnosis** | **Family Member(s)** |
| **Heart Disease / Heart Attack** |  |
| **Diabetes Type I or II** |  |
| **Asthma** |  |
| **Dementia** |  |



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| **Prescription Medications** |
| **Medication** | **Current Dose** | **How Often** | **Start Date** | **Taken for What** |
|  |  |  | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ |  |
|  |  |  | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ |  |
|  |  |  | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ |  |
|  |  |  | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ |  |
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|  |  |  | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ |  |
|  |  |  | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ |  |
| **Over the Counter Medications** |
| **Medication** | **Current Dose** | **How Often** | **Start Date** | **Taken for What** |
|  |  |  | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ |  |
|  |  |  | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ |  |
|  |  |  | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ |  |
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| **Review of Body Systems** |
| **Please indicate if you have any of the following:** |
| **Eyes** | **Start Date** | **Stop Date or Ongoing** |
| [ ]  Cataracts [ ]  Right [ ]  Left | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ Or [ ]  Ongoing |
| [ ]  Macular Degeneration | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ Or [ ]  Ongoing |
| [ ]  Glaucoma | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ Or [ ]  Ongoing |
| [ ]  Diabetic Retinopathy | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ Or [ ]  Ongoing |
| **Ear, Nose, and Throat** | **Start Date** | **Stop Date or Ongoing** |
| [ ]  Seasonal Allergies or  Allergic Rhinitis | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ Or [ ]  Ongoing |
| [ ]  Impaired Hearing | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ Or [ ]  Ongoing |
| [ ]  Chronic Sinusitis | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ Or [ ]  Ongoing |
| **Respiratory** | **Start Date** | **Stop Date or Ongoing** |
| [ ]  Asthma | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ Or [ ]  Ongoing |
| [ ]  Chronic Bronchitis | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ Or [ ]  Ongoing |
| [ ]  COPD | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ Or [ ]  Ongoing |
| [ ]  Emphysema | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ Or [ ]  Ongoing |
| [ ]  Chronic Pneumonia | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ Or [ ]  Ongoing |
| [ ]  Sleep Apnea [ ]  Use CPAP | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ Or [ ]  Ongoing |
| [ ] Tuberculosis | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ Or [ ]  Ongoing |
| **Cardiovascular** | **Start Date** | **Stop Date or Ongoing** |
| [ ]  Angina (Chest Pain) | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ Or [ ]  Ongoing |
| [ ]  Heart Murmur | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ Or [ ]  Ongoing |
| [ ]  Heart Attack | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ Or [ ]  Ongoing |
| [ ]  Irregular Heart Beat  (Atrial Fibrillation) | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ Or [ ]  Ongoing |
| [ ]  High Blood Pressure | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ Or [ ]  Ongoing |
| [ ]  High Cholesterol / Lipids | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ Or [ ]  Ongoing |
| [ ]  Coronary Artery Disease | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ Or [ ]  Ongoing |
| [ ]  Congestive Heart Failure  | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ Or [ ]  Ongoing |
| [ ]  Peripheral Vascular Disease | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ Or [ ]  Ongoing |



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| **Gastrointestinal** | **Start Date** | **Stop Date or Ongoing** |
| [ ]  Acid Reflux / GERD | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ Or [ ]  Ongoing |
| [ ]  Ulcers | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ Or [ ]  Ongoing |
| [ ]  Hernia Type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ Or [ ]  Ongoing |
| [ ]  Gastric Polyps | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ Or [ ]  Ongoing |
| [ ]  Hemorrhoids | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ Or [ ]  Ongoing |
| [ ]  Diverticulitis | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ Or [ ]  Ongoing |
| [ ]  Irritable Bowel Syndrome | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ Or [ ]  Ongoing |
| [ ]  Inflammatory Bowel Disease | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ Or [ ]  Ongoing |
| [ ]  Chronic Constipation | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ Or [ ]  Ongoing |
| [ ]  Chronic Diarrhea | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ Or [ ]  Ongoing |
| [ ]  Gallstones | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ Or [ ]  Ongoing |
| **Endocrine / Metabolic** | **Start Date** | **Stop Date or Ongoing** |
| [ ]  Diabetes Mellitus Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ Or [ ]  Ongoing |
| [ ]  Hypoglycemia (Low Blood  Sugar) | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ Or [ ]  Ongoing |
| [ ]  Hyperthyroidism (Overactive) | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ Or [ ]  Ongoing |
| [ ]  Hypothyroidism (Underactive) | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ Or [ ]  Ongoing |
| [ ]  Thyroid Nodule | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ Or [ ]  Ongoing |
| [ ]  Gout | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ Or [ ]  Ongoing |
| [ ]  Vitamin Deficiency Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ Or [ ]  Ongoing |
| **Hematologic** | **Start Date** | **Stop Date or Ongoing** |
| [ ]  Clotting Disorder | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ Or [ ]  Ongoing |
| [ ]  Chronic Anemia | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ Or [ ]  Ongoing |
| **Immunologic** | **Start Date** | **Stop Date or Ongoing** |
| [ ]  HIV/AIDS | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ Or [ ]  Ongoing |
| [ ]  Lupus | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ Or [ ]  Ongoing |
| [ ]  Cancer Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ Or [ ]  Ongoing |



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| **Hepatic** | **Start Date** | **Stop Date or Ongoing** |
| [ ]  Liver Disease | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ Or [ ]  Ongoing |
| [ ]  Fatty Liver Disease | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ Or [ ]  Ongoing |
| [ ]  Hepatitis B, or C Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ Or [ ]  Ongoing |
| **Renal** | **Start Date** | **Stop Date or Ongoing** |
| [ ]  Kidney Stones | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ Or [ ]  Ongoing |
| [ ]  Recurrent Kidney Infections | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ Or [ ]  Ongoing |
| [ ]  Chronic Kidney Disease | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ Or [ ]  Ongoing |
| **Urogenital / Gynecologic** | **Start Date** | **Stop Date or Ongoing** |
| [ ]  Overactive Bladder | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ Or [ ]  Ongoing |
| [ ]  Uterine Fibroids | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ Or [ ]  Ongoing |
| [ ]  Uterine Cysts | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ Or [ ]  Ongoing |
| [ ]  Endometriosis | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ Or [ ]  Ongoing |
| [ ]  Erectile Dysfunction | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ Or [ ]  Ongoing |
| [ ]  Benign Prostate Hypertrophy (BPH) | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ Or [ ]  Ongoing |
| Males Method of Contraception: [ ]  NA, Female[ ]  Vasectomy [ ]  Condoms/Spermicide [ ]  Abstinence [ ]  Sterile Partner [ ]  None [ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Females Reproductive History: [ ]  NA, MaleAre you currently Pregnant, Lactating, or Breast Feeding? [ ]  Yes [ ]  NoPlease specify: # of pregnancies: \_\_\_\_\_\_ # of Live Births: \_\_\_\_\_\_\_  # of C-Sections: \_\_\_\_\_\_ with dates: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_, \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_\_ Check all reproductive procedures you have received: [ ]  Bilateral Tubal Ligation, Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_\_ [ ]  Partial Hysterectomy, Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_\_[ ]  Complete Hysterectomy, Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_\_ [ ]  Bilateral Oophorectomy, Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_\_[ ]  Uterine Ablation, Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_\_ [ ]  IUD Placement, Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_\_[ ]  Contraceptive Implant Placement, Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_\_\_\_When was your last Menstrual Period? \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ If no longer having Menstrual Periods, was this Spontaneous or due to a procedure? [ ]  Spontaneous [ ]  ProcedureCurrent Method of Contraception: [ ]  Surgically Sterile [ ]  Postmenopausal [ ]  Oral Contraceptives [ ]  Transdermal Patch Contraceptive [ ]  IUD [ ]  Contraceptive Implant [ ]  Condoms/Spermicide [ ]  Abstinence [ ]  Sterile Partner [ ]  None  [ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |



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| **Musculoskeletal** | **Start Date** | **Stop Date or Ongoing** |
| [ ]  Osteoarthritis Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ Or [ ]  Ongoing |
| [ ]  Rheumatoid Arthritis | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ Or [ ]  Ongoing |
| [ ]  Fibromyalgia | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ Or [ ]  Ongoing |
| **Psychiatric** | **Start Date** | **Stop Date or Ongoing** |
| [ ]  Anxiety or Panic Attacks | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ Or [ ]  Ongoing |
| [ ]  Depression | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ Or [ ]  Ongoing |
| [ ]  Bipolar Disorder | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ Or [ ]  Ongoing |
| [ ]  Schizophrenia  | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ Or [ ]  Ongoing |
| **Neurologic** | **Start Date** | **Stop Date or Ongoing** |
| [ ]  Insomnia | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ Or [ ]  Ongoing |
| [ ]  Migraine Headaches | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ Or [ ]  Ongoing |
| [ ]  Chronic Headaches | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ Or [ ]  Ongoing |
| [ ]  Seizure Disorder | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ Or [ ]  Ongoing |
| [ ]  Stroke / TIA | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ Or [ ]  Ongoing |
| [ ]  Alzheimer’s Disease | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ Or [ ]  Ongoing |
| [ ]  Memory Problems / Dementia | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ Or [ ]  Ongoing |
| [ ]  Diabetic Peripheral Neuropathy | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ Or [ ]  Ongoing |
| [ ]  Post-Herpetic Neuralgia (PHN) | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ Or [ ]  Ongoing |
| **Skin** | **Start Date** | **Stop Date or Ongoing** |
| [ ]  Psoriasis | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ Or [ ]  Ongoing |
| [ ]  Eczema | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ Or [ ]  Ongoing |



**2700 Old Winter Garden Road**

**Ocoee, FL 34761**

**407-654-2724**

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| --- |
| **Surgical History** |
| **Surgery** | **Date** | **Reason for Surgery** |
|  | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ |  |
|  | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ |  |
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|  | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ |  |
| Do you anticipate or expect surgery in the next year? [ ]  Yes [ ]  NoIf yes, please specify surgery/reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Any Other Medical Conditions** |
| **Diagnosis** | **Date** | **Stop Date or Ongoing** |
|  | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ |  |
|  | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ |  |
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|  | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ |  |

**Patient Signature : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date : \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_**

**CRC/Investigator Signature : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date : \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_**