

**2700 Old Winter Garden Road**

**Ocoee, FL 34761**

**407-654-2724**

**Intake Form**

|  |
| --- |
| **Demographic Information** |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (LEGAL NAME) Date: \_\_\_\_\_\_\_ / \_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_\_  FIRST MIDDLE LAST  Date of Birth: \_\_\_\_\_\_\_ / \_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_ Sex:  Male  Female  Race:  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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |



**2700 Old Winter Garden Road**

**Ocoee, FL 34761**

**407-654-2724**

|  |  |  |  |
| --- | --- | --- | --- |
| **Tobacco History** | | | |
| Have you ever Smoke Tobacco Products?  Yes  No  Type 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  No  Type 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** | |  | |



**2700 Old Winter Garden Road**

**Ocoee, FL 34761**

**407-654-2724**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Prescription Medications** | | | | |
| **Medication** | **Current Dose** | **How Often** | **Start Date** | **Taken for What** |
|  |  |  | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ |  |
|  |  |  | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ |  |
|  |  |  | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ |  |
|  |  |  | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ |  |
|  |  |  | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ |  |
|  |  |  | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ |  |
|  |  |  | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ |  |
|  |  |  | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ |  |
|  |  |  | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ |  |
|  |  |  | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ |  |
|  |  |  | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ |  |
|  |  |  | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ |  |
| **Over the Counter Medications** | | | | |
| **Medication** | **Current Dose** | **How Often** | **Start Date** | **Taken for What** |
|  |  |  | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ |  |
|  |  |  | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ |  |
|  |  |  | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ |  |
|  |  |  | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ |  |
|  |  |  | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ |  |
|  |  |  | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ |  |
|  |  |  | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ |  |
|  |  |  | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ |  |
|  |  |  | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ |  |
|  |  |  | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ |  |
|  |  |  | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ |  |
|  |  |  | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ |  |



**2700 Old Winter Garden Road**

**Ocoee, FL 34761**

**407-654-2724**

|  |  |  |
| --- | --- | --- |
| **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 |



**2700 Old Winter Garden Road**

**Ocoee, FL 34761**

**407-654-2724**

|  |  |  |
| --- | --- | --- |
| **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 |



**2700 Old Winter Garden Road**

**Ocoee, FL 34761**

**407-654-2724**

|  |  |  |
| --- | --- | --- |
| **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, Male  Are you currently Pregnant, Lactating, or Breast Feeding?  Yes  No  Please 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  Procedure  Current Method of Contraception:  Surgically Sterile  Postmenopausal  Oral Contraceptives  Transdermal Patch Contraceptive  IUD  Contraceptive Implant  Condoms/Spermicide  Abstinence  Sterile Partner  None  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |



**2700 Old Winter Garden Road**

**Ocoee, FL 34761**

**407-654-2724**

|  |  |  |
| --- | --- | --- |
| **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**

|  |  |  |
| --- | --- | --- |
| **Surgical History** | | |
| **Surgery** | **Date** | **Reason for Surgery** |
|  | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ |  |
|  | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ |  |
|  | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ |  |
|  | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ |  |
|  | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ |  |
|  | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ |  |
|  | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ |  |
|  | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ |  |
|  | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ |  |
|  | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ |  |
|  | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ |  |
| Do you anticipate or expect surgery in the next year?  Yes  No  If yes, please specify surgery/reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **Any Other Medical Conditions** | | |
| **Diagnosis** | **Date** | **Stop Date or Ongoing** |
|  | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ |  |
|  | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ |  |
|  | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ |  |
|  | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ |  |
|  | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ |  |
|  | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ |  |
|  | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ |  |
|  | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ |  |
|  | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ |  |
|  | \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_\_\_\_ |  |

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

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