

Medical History Questionnaire

The information requested below will assist the physician with your medical evaluation. Please fill out this form as legibly as possible. Please bring the completed form with you to your appointment, mail it to our Naples office or fax it directly to us at 239-263-8592 prior to your appointment date. We appreciate your time.

Date: _____

Patient Name: _____

Local Address: _____

City: _____ State: _____ Zip: _____

Local Phone: _____ Cell Phone: _____ Date of Birth: _____

Email address: _____

SS#: _____ Marital Status: Married _____ Single _____ Divorced _____ Widow _____

Sex: M _____ F _____ Out of State Address: _____

City, State, Zip: _____ Phone Number: _____

Emergency Contact: _____ Relationship: _____

Name Phone #

Employer: _____ Employer Phone: _____

Employer Address: _____

Insurance Information:

Primary Insurance:

Insurance Name: _____ Policy #: _____

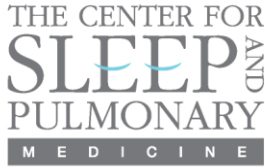
Group # _____ Insured's Employer: _____

Policy Holder's Name: _____ Relationship to Patient: _____

Policy Holder's Date of Birth: _____ Policy Holder's SS #: _____

Insurance Address: _____ Ins. Phone #: _____

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Secondary Insurance:

Insurance Name: _____ Policy #: _____

Group #: _____ Insured's Employer: _____

Policy Holder's Name: _____ Relationship to Patient: _____

Policy Holder's Date of Birth: _____ Policy Holder's SS #: _____

Insurance Address: _____ Ins. Phone #: _____

Pharmacy Information: (We request the name of a local pharmacy to use for urgent prescriptions)

Preferred local pharmacy: _____ Address: _____

Mail order pharmacy: _____ ID Number: _____

Please Present Insurance Cards to Front Desk

Occupation: _____ Are you currently working? _____

Are you disabled and unable to work? _____

Religion: _____

Race: Black _____ White _____ Hispanic _____ Asian _____ Other _____

Were you referred by a physician that we can send your report to? ___ Yes ___ No

Physician's name: _____ Phone number _____

Address: (incl. zip) _____

Specialty: _____

Do you have a primary care physician? _____ Yes _____ No

Physician's name: _____ Phone number _____

Address: (incl. zip) _____

What is the chief problem that brings you here today?

How long have you had this problem? _____

What do you think might be causing it? _____

Advance Directives

In the event you become incapacitated and are unable to make decisions concerning your care have you made any of the following arrangements?

Completing a living will? ____Yes____ No (If yes, please bring a copy for your medical records)

Designating a health-care surrogate decision-maker? ____Yes____ No (If yes, please complete the below)

Name: _____ Address: _____

Phone: _____

Past Medical History:

Hospitalizations (Year):	Diagnosis:	Surgery: (if any)
_____	_____	_____
_____	_____	_____

Other serious illnesses (Year):	Diagnosis and treatment:
_____	_____
_____	_____

Smoking History:

Are you smoking now? ____Y____N Are you willing to consider quitting? ____Y____N

Have you smoked in the past? ____Y____N Date or age at which you quit _____

Cigarettes _____ Cigars _____ Pipe _____

Average number per day _____pack _____ other

Medications: Please bring a list of all medications currently being taken, including vitamins, herbal and over-the-counter drugs. Include the name of the medication and the dosage. If you are unable to provide a list, complete the following (name and dosage):

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Allergies: List all medications and other substances to which you are allergic and describe your reaction:

_____	_____
_____	_____
_____	_____

Immunizations:

Have you received Pneumonia vaccine? ____ Yes ____ No _____ Date

Do you receive an annual Influenza vaccine? ____ Yes ____ No _____ Date

X-ray studies: Have you had any of the following x-ray studies performed within the past three years? (Include the date, location, and result if known)

Chest x-ray ____ Yes ____ No _____ Location _____ Result

CT scan of chest ____ Yes ____ No _____ Location _____ Result

Pulmonary Function Studies (breathing tests): Have you had pulmonary function studies performed within the past 3 years? (Include the date, location, and result if known)

____ Yes ____ No _____ Location _____ Result

Sleep Studies: Have you had a sleep study performed in the past? (Include the date, location, and result if known)

____ Yes ____ No _____ Location _____ Result

Pain:

Are you presently or intermittently bothered by pain? ____ Yes ____ No

If yes, what causes your pain? _____

Location and duration _____

Would you describe the pain as ____ Crushing ____ Stabbing ____ Tight ____ Sharp ____ Burning

On a scale of 1 -10 described the intensity of your pain _____

What relieves your pain? _____

Sleep disorders: if the answer to any of these questions is yes, please bring your bed partner to your visit and be sure to complete the separate sleep questionnaire

Do you snore? ____ Yes ____ No ____ I have been told that I snore

Do you usually wake up feeling refreshed? ____ Yes ____ No

Are you usually excessively tired and sleepy during the day? ____ Yes ____ No

Do you often have difficulty getting to sleep or staying asleep? ____ Yes ____ No

Signature of Patient _____ **Date** _____