

Korunda Medical Institute

4513 Executive Drive; Naples, FL 34119 Phone (239) 431-6464; Fax (239) 594-5637

Patient Medical History

Date: _____

Last Name	First	Middle	Date of Birth	Sex		Marital Status				
				M	F	S	M	W	D	Sep
Occupation			Employer's Name & Address							
Any Children:			If so, number & Age(s):							
Do you have any Religious or cultural practices that may affect healthcare or treatment?			No		If yes, in what way?					
			Yes							

List other Physicians you see:

Reason for visit/chief complaint:

Do you have a living will? No Yes Have you designated a health care surrogate? No Yes

Name and Phone number of surrogate: _____

Have you completed Do Not Resuscitate form? No Yes Are you an organ Donor? No Yes

Medical History

Have you previously had or been suspected to have had:

Neurologic/Psychiatric

Stroke	No	Yes	TIA (stroke symptoms <24hrs)	No	Yes	Epilepsy	No	Yes
Sleeping problems	No	Yes	Depression	No	Yes	Other: _____		

Eyes

Glaucoma	No	Yes	Other eye disorder	No	Yes	Other eye disease	No	Yes
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Ears/Nose/Mouth/Throat

Disorders of ears/hearing and or balance	No	Yes
Problems with nasal allergies, obstruction or bleeding	No	Yes
Mouth, throat or swallowing problems	No	Yes

Lung/Pulmonary

Asthma	No	Yes	Recurring bronchitis	No	Yes	Emphysema	No	Yes
Chronic lung disease	No	Yes						

Cardiac

Heart attack/MI	No	Yes	Angina/Chest pain	No	Yes	Abnormal Heart Tracing	No	Yes
Heart catheterization	No	Yes	High blood pressure	No	Yes	Murmur	No	Yes
Stress Test	No	Yes						

Gastrointestinal

Gastritis	No	Yes	Esophagitis	No	Yes	Reflux	No	Yes
Upper/lower GI bleeding	No	Yes	Ulcer disease	No	Yes	Colon disease/polyps	No	Yes
Diverticulitis	No	Yes	Liver disease/jaundice	No	Yes	Hepatitis	No	Yes

GU/GYN

Kidney disease	No	Yes	Urine/bladder infection	No	Yes	Diffic. controlling bladder	No	Yes
Uterine/ovarian problem	No	Yes	Prostate enlargement	No	Yes	Prostate infection	No	Yes
Prostate cancer	No	Yes				Any sexually transmitted disease	No	Yes

When was your last menstrual flow? _____

Musculoskeletal

Abnormal muscle function	No	Yes	Loss of joint function	No	Yes	Bothersome spine/joint	No	Yes
Arthritis pain	No	Yes	Bone/joint replacement	No	Yes	Pain	No	Yes

Skin

History of skin disease	No	Yes	History of cancer	No	Yes	Current skin problems	No	Yes
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Endocrinology

Diabetes/high sugar	No	Yes	Thyroid disorder (high/low)	No	Yes	Other hormonal problems	No	Yes
recent steroid use (cortisone or prednisone)				No	Yes			

Hematology

Bleeding disorder/Sickle cell	No	Yes	Prolonged bleeding from cuts	No	Yes	Anemia	No	Yes
Phlebitis/blood clots in legs	No	Yes	Blood transfusion	No	Yes	Immune problems/AIDS/HIV	No	Yes

Serious Injuries/Accidents:

Surgical and Procedure History

Have you had any of the following surgeries and when?

Hernia	_____	Gallbladder	_____	Heart Surgery	_____
Appendectomy	_____	Tonsillectomy	_____	Sinus surgery	_____
Gastrointestinal surgery	_____	Lung/pulmonary surgery	_____	Hysterectomy	_____
Other:	_____				

Have you had any of the following procedures and when?

Colonoscopy	_____	EGD (gastroscopy)	_____	Other:	_____
Last mammogram	_____	Last bone density test	_____	Last chest x-ray	_____
Last lab work	_____	Last ECG	_____	Last Echo/cardiac testing	_____

Medications - Please list current medications (including non-prescription medication)

Vaccinations

Last Tetanus shot	_____	Last Pneumococcal vaccine	_____	Last influenza vaccine	_____
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Drug Allergies/Sensitivities:

Personal Habits (Circle)

Do you smoke? No Yes Quit date _____

Have you ever smoked? No Yes Cigarettes ____ Pipes ____ Cigars ____ How many years? _____ How much per day? _____

Do you usually drink over six cups of coffee per day? No Yes

Do you regularly drink alcohol? No Yes 1 oz per day ____ 2 oz per day ____ 4 oz per day ____ 6 oz or more per day ____

Beer: 1 bottle per day ____ 2 bottles per day ____ 4 bottles or more per day ____

Have you taken any recreational drugs? No Yes Type: _____

Family History

Please circle yes or no if an immediate family member has been affected with any of following: (example: parents, siblings, children)

Cancer	No	Yes	Hypertension	No	Yes	Asthma	No	Yes
Stroke	No	Yes	Lung Disease	No	Yes	Allergies	No	Yes
Epilepsy or seizures	No	Yes	Tuberculosis	No	Yes	Glaucoma	No	Yes
Bleeding problems	No	Yes	Diabetes mellitus	No	Yes	Ulcers	No	Yes

Blood disorders	No	Yes	Thyroid disease	No	Yes	Migraines	No	Yes
Heart disease	No	Yes	Neuromuscular disease	No	Yes	Colitis	No	Yes
Rheumatic fever/heart	No	Yes	Liver disease	No	Yes	Mental illness	No	Yes
Heart attack	No	Yes	Kidney disease	No	Yes	Depression	No	Yes
Angina	No	Yes	Kidney stones	No	Yes	Suicide	No	Yes
Circulation problems	No	Yes	Leukemia	No	Yes	Arthritis	No	Yes