West Coast Family Practice
For your Health

Gail Sadler, APRN-BC *Oswald Williams, MD* *Theata J. Merritt, APRN-BC*

11018 N. Dale Mabry Hwy, Ste. 401, Tampa, FL 33618 PH: 813-961-9393 FX: 813-960-9020

PATIENT HISTORY

Date Today:

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.):*		☐ Male ☐ Female	**DOB:**	/ /	
Marital status:	☐ Single ☐ Married ☐ Male Partner ☐ Female Partner ☐ Separated ☐ Divorced ☐ Widowed ☐ Never Married				
Employment:	☐ Retired ☐ Full- Time ☐ Part-Time ☐ Unemployed ☐ Self Employed ☐ Military ☐ Homemaker				
Education:	☐ High School ☐ Undergraduate ☐ Graduate ☐ Doctorate	Other:			
Religion:		**Living With:**	☐ Alone ☐ Spouse ☐ Significant Other ☐ Family ☐ Friends		
Travel:	☐ None in last six months ☐ Travels to South Africa ☐ Travels to Europe ☐ Travels to Asia ☐ Travels to Africa				
Occupational Exposure:	☐ None ☐ Toxic Chemicals ☐ Noise Exposure ☐ Infectious Agents ☐ Repetitive Physical Stress				
Domestic Violence:	☐ None ☐ History in Past ☐ Have Restraining Order ☐ Feels unsafe at home ☐ Have safety plan				

PERSONAL HEALTH HISTORY

Previous or referring doctor:		Date of last physical exam:	
Childhood illness:	☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio		
Immunizations and dates:	☐ Tetanus	☐ Pneumonia	
	☐ Hepatitis	☐ Chickenpox	
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella*	

List any medical problems that other doctors have diagnosed:

Laboratory Tests Completed:	Date:	Who Ordered?	**Type Diagnostic /Imaging Completed:**	Date:	Facility:	Who Ordered?

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion?	☐ Yes	☐ No

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List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name the Drug	Strength	Frequency Taken

Allergies to medications

Name the Drug	Reaction You Had	Name the Drug	Reaction You Had

SOCIAL HISTORY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	☐ Sedentary (No exercise)	☐ Difficult due to weight	☐ Occasionally			
	Exercise Frequency:	☐ Weekly	☐ Daily	☐ 2 times/week	☐ 3 times/week	☐ 1-2 times/week	☐ 2-3 times/week
	☐ 3-4 times/week	☐ Less than 30 min./day	☐ 30-60 minutes/day	☐ 1-2 hours/day		
	☐ Type of Exercise: (i.e. golf, bicycling, walking, running, swim, weights):					
Diet	☐ Diabetic Diet	☐ Cardiac Diet	☐ Un-Restricted Diet	☐ Low Carbohydrate	☐ Low Fat	☐ Vegetarian	☐ Vegan
	☐ Eat out several days a week	☐ Drink high sugar beverages	☐ Low salt Diet	☐ Low Cholesterol Diet	☐ Low Sugar Diet		
	# of meals you eat in an average day?						
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola			
	# of cups/cans per day?						
Alcohol	**Do you drink alcohol?**	☐ Yes ☐ No	History of Alcohol Use?	☐ Yes ☐ No How many Years? _____			
	If yes, what kind?						
	How often do you drink alcohol?	Socially ☐	Daily ☐	Occasionally ☐	Rarely ☐		
	How many do you drink?	1-2 day ☐	2-3 day ☐	3-5 day ☐	More than 5 ☐		
	Have you ever experienced blackouts?					☐ Yes	☐ No
Drugs	Do you currently use recreational or street drugs?					☐ Yes	☐ No
	Have you ever used recreational drugs? ☐ Yes ☐ No	If yes, what date/year(s) ago did you quit?					
	Have you ever given yourself street drugs with a needle?					☐ Yes	☐ No

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Tobacco

Are you a current smoker? ☐ Yes ☐ No	# of years:	Year Quit Smoking:
Status: ☐ Former Smoker ☐ Non-Smoker ☐ Current Every day smoker ☐ Current Occasional Smoker ☐ Unknown		
☐ Light cigarette smoker (1-9/day) ☐ Moderate cigarette smoker (10-19/day) ☐ Heavy cigarette smoker (20-39/day)		
If Current Tobacco User: What type of tobacco do you use? Other forms of tobacco : ☐ Chew ☐ Pipe		
☐ Chew fine cut tobacco ☐ Chew Loose leaf tobacco ☐ Chew plug tobacco ☐ Chew twist tobacco ☐ Pipe Smoker		
If Current Smoker: How often do you smoke cigarettes? ☐ Every day ☐ Some days, but not every day		
How many Cigarettes a day do you smoke? ☐ 5 or less ☐ 6-10 ☐ 11-20 ☐ 21-30 ☐ 30 or more / full pack		

If Current Smoker: How soon after you wake up do you smoke your first cigarette?	
☐ within 5 minutes ☐ 6-30 minutes ☐ 31-60 minutes ☐ after 60 minutes	
If Current Smoker: Are you interested in quitting?	☐ Yes ☐ No
☐ Ready to Quit ☐ Thinking about quitting ☐ Not ready to quit	
If Former Smoker: How long has it been since you last smoked?	
☐ 1-3 months ☐ < 1 month ☐ 3-6 months ☐ 6-12 months ☐ 1-5 years ☐ 5-10 years ☐ > 10 years	

FAMILY HEALTH HISTORY

PLEASE CHECK (√) ALL THAT APPLY

MEMBERS	STATUS *(deceased or alive)*	YOB	AGE	Diabetes	High Blood Pressure	Heart Disease	Stroke	Cancer	Mental Disease	Unknown
FATHER										
MOTHER										
BROTHER (s) #____										
SISTER (s) #____										
SON (s) #____										
DAUGHTER (s) #____										
GRANDFATHER *(Paternal)*										
GRANDMOTHER *(Paternal)*										
GRANDFATHER *(Maternal)*										
GRANDMOTHER *(Maternal)*										
Other (s):										