



Name:

DOB:

Reason For Today's Visit:

Past Medical History:

Past Surgical History/Dates:

Family History: List current age if living OR age of death if deceased. List major medical problems.

Mother: _____ Father: _____

Siblings: _____

Children: _____

Other: _____

Social History:

Marital Status: _____ Occupation: _____

Tobacco Use: _____ Packs/day: _____ # of Years: _____ Quit Year: _____

Alcohol Use: _____ Diet: _____ Exercise Level: _____

Birthplace: _____

Are you a part-time Florida Resident: Y/N If Yes, where is your Primary Residence: _____





Name:

DOB:

Allergies:

Medications:

Other Providers:

Screening:

Immunization/Date: Influenza: _____ Pneumonia: _____ Shingles: _____ Tetnus: _____ Other _____

Breast Cancer Screening: Exam Date: _____ Mammogram: _____ Self Exams: Y/N

PAP/Pelvic: _____ HPV Status: _____ Prostate Cancer Screening: Exam: _____ PSA: _____

Colon Cancer Screening: Colonoscopy: _____

Glaucoma Screening/Dilated Eye Exam: _____ Date of Last Dental Exam: _____

Date of Last Labs: _____ Aortic Aneurysm Screening: _____

Home Safety Concerns: _____ Do You Have An Advanced Directive or a Living Will? Y/N

The purpose of this form is to provide Dr. Cooke with all information necessary to fully evaluate you. If incomplete, it will be returned to you for completion. If you do not know an answer, write UNKNOWN.

