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Northwest Florida Clinical Research Group, LLC

Adult Patient History

Name: _____ SSN: _____
Last First MI

Date of Birth: ____/____/____ City/State of Birth: _____

Address: _____
Street Apt City State Zip

Home Phone Number: (___)_____ Cell Phone Number: (___)_____

Work Phone Number: (___)_____

Please complete this section for all people who live in the same home as you.

Name	How related?	Age	Occupation	Education

Who is your primary doctor? _____(___)_____
Name Phone

Please tell us about other doctors you also see.

Name of Doctor	Address	Phone	Why seen

What pharmacy do you usually use? _____(___)_____
Name Location Phone

Why are we seeing you today? _____

_____

Please tell us about your past medical history.

1. Hospitalizations:

Name and location of hospital	When hospitalized	Why hospitalized

2. Surgeries:

Type of surgery	When Done	Name and location of hospital

3. Do you have any allergies?:

Allergy	Reaction

4. What other medical problems do you have?

System	Type of problem(s)
Heart/blood vessels	
Breathing	
Skin	
Psychiatric/emotional	
Eyes/ears/nose/throat	
Stomach/intestines	
Kidneys/bladder	
Immune system	
Muscles/bones	
Brain/nerves	
Reproductive (women)	Last menstrual period? _____ Number of pregnancies: _____ Number of children: _____
Prostate (men)	
Other	

5. What medicines are you currently taking?

Name	Amount taken	How often taken	Why taken

6. What medicines have you taken in the past?

Name	When stopped	Why stopped

7. Do you have a family history of any of the following?

Headaches	Strokes	High B/P	Brain or nerve problems
Tics	Psychiatric or emotional problems	Muscles weakness problems	Seizures

Please attach a recent photograph if one is available.

Patient Name: _____ DOB: _____

Signature: _____ Date: _____

MD/ARNP Signature: _____ Date: _____