THE MAGNOLIA MEDICAL GROUP

8031 Phillips Hwy. Suite 6
Jacksonville, FL. 32256
Office: 904-737-6313 Fax: 904-739-1302

5851 Timuquana Rd. #201
Jacksonville, FL. 32210
Office: 904-779-2220 Fax: 904-779-2227

HEALTH HISTORY FORM

Patient Name: _____ Birth Date: _____

Health Habits:
Exercise ☐ None ☐ Mild (Climb stairs, walk 3 blocks, golf) ☐ Occasional Vigorous (work or recreation less than 4x a week for 30 min) ☐ Regular Vigorous (work or recreation 4x a week for 30 min)

Diet Are you dieting? ☐ Yes ☐ No If yes, are you on a physician prescribed medical diet? ☐ Yes ☐ No

Caffeine ☐ None ☐ Coffee ☐ Tea ☐ Cola # of cups/cans per day? _____

Alcohol Do you drink Alcohol? ☐ Yes ☐ No If yes, what kind? _____
How many drinks per week? _____ How long have you been drinking? (# of years) _____

Tobacco Do you use tobacco? ☐ Yes ☐ No # of years _____ Years quit? _____
Cigarettes - pkgs/day _____ Pipe - #/day _____ Cigars - #/day _____ Chew - #/day _____

Family History: Has any blood relative ever had the following:

Breast Cancer ..... ☐ no ☐ yes	High Blood Pressure.... ☐ no ☐ yes	Kidney Disease..... ☐ no ☐ yes
Ovarian Cancer..... ☐ no ☐ yes	Heart Disease..... ☐ no ☐ yes	Depression..... ☐ no ☐ yes
Stroke..... ☐ no ☐ yes	Diabetes ..... ☐ no ☐ yes	Melanoma..... ☐ no ☐ yes

Other _____

Past Medical History: Have you ever had the following:

Heart Disease..... ☐ no ☐ yes	Diabetes ..... ☐ no ☐ yes	Chronic Fatigue..... ☐ no ☐ yes
Chest Pain..... ☐ no ☐ yes	Cancer..... ☐ no ☐ yes	Stomach Ulcer..... ☐ no ☐ yes
Blood Clots..... ☐ no ☐ yes	Glaucoma..... ☐ no ☐ yes	Kidney Disease..... ☐ no ☐ yes
Arthritis ..... ☐ no ☐ yes	Asthma..... ☐ no ☐ yes	Thyroid Disease ..... ☐ no ☐ yes
Tuberculosis ..... ☐ no ☐ yes	AIDS or HIV ..... ☐ no ☐ yes	Bleeding Tendency..... ☐ no ☐ yes
Rheumatic Fever..... ☐ no ☐ yes	Stroke..... ☐ no ☐ yes	Mitral Valve Prolapse..... ☐ no ☐ yes
Anemia ..... ☐ no ☐ yes	Hepatitis..... ☐ no ☐ yes	High Blood Pressure ..... ☐ no ☐ yes
Heart Attack ..... ☐ no ☐ yes	Lung Problems..... ☐ no ☐ yes	Emphysema/COPD ..... ☐ no ☐ yes
Kidney Stones..... ☐ no ☐ yes	STD History..... ☐ no ☐ yes	Gout..... ☐ no ☐ yes
Osteoporosis ..... ☐ no ☐ yes	Palpitations ..... ☐ no ☐ yes	Fainting/Dizzy Spells ..... ☐ no ☐ yes
Heartburn..... ☐ no ☐ yes	Sinus trouble..... ☐ no ☐ yes	Allergies ..... ☐ no ☐ yes
Leg Blood Clots..... ☐ no ☐ yes	Swollen Ankles..... ☐ no ☐ yes	Constipation ..... ☐ no ☐ yes
Bloody/Tarry Stool.... ☐ no ☐ yes	Diverticulitis..... ☐ no ☐ yes	Abdominal Pain..... ☐ no ☐ yes
Hemorrhoids..... ☐ no ☐ yes	Back Pain..... ☐ no ☐ yes	Shoulder Pain ..... ☐ no ☐ yes
Knee Pain ..... ☐ no ☐ yes	Foot Pain..... ☐ no ☐ yes	Gallbladder..... ☐ no ☐ yes
Seizures ..... ☐ no ☐ yes	Hearing Problems ... ☐ no ☐ yes	Headaches ..... ☐ no ☐ yes
Vision Problems ..... ☐ no ☐ yes	Depression ..... ☐ no ☐ yes	Sleep Problems..... ☐ no ☐ yes

High Cholesterol..... ☐ no ☐ yes Ulcer ..... ☐ no ☐ yes Liver Disease ..... ☐ no ☐ yes
Urinary Disorders ..... ☐ no ☐ yes Eye Disease ..... ☐ no ☐ yes Drug Addictions ..... ☐ no ☐ yes
Gastric Reflux..... ☐ no ☐ yes - if yes are you on medication for this? (name) _____

Women Only: Birth Control Pills ☐ no ☐ yes

Number of children: _____ Last menstrual period _____

Date of last mammogram _____ Breast lump or discharge _____

Date of last pap _____

Current Medications (including over the counter drugs, aspirin, and nose sprays)

Drug Name	**Dosage**	**Times per day**

Medication Allergies	**Type of Reaction**