Advance Preventive Medicine
1400 E Robinson St Orlando 32801

Patients Name: _____

Welcome to our office

Date of Birth: _____ Insurance name: ----------

Medical Record #: _____ Social Security: ----------

Primary Care Provider: _____ Patient phone #----------

Drug Allergies/Sensitivities: _____ Patient address: ----------

Emergency Phone #: _____ Contact Relationship: _____Patient email: ----------

ICD Code	Medical Problem List	Date	Past Surgical History	Date
			Hospitalizations and Reasons	**Date**
			Vaccine record	Date

Family History of

Y	N		Family Member
☐	☐	Alzheimer	_____
☐	☐	Breast CA	_____
☐	☐	Heart	_____
☐	☐	Stroke	_____
☐	☐	Cancer history	_____
☐	☐	Colon CA	_____
☐	☐	Depression	_____
☐	☐	DM	_____
☐	☐	Vision	_____
☐	☐	Glaucoma	_____
☐	☐	cholesterol	_____
☐	☐	HTN	_____
☐	☐	Mental issue	_____
☐	☐	Prostate CA	_____
☐	☐	Skin CA	_____
☐	☐	Thyroid	_____

Initial Risk Assessment

	Date
☐ Alcohol/Drug Use	_____
☐ STDs	_____
☐ Domestic Violence	_____
☐ Depression	_____
☐ Osteoporosis	_____
☐ Geriatric Assessment	_____
☐ MMSE	_____
☐ Screenings	_____

Social History

☐ Married ☐ Single ☐ Civil Union

☐ Divorced ☐ Widowed

☐ Lives Alone ☐ Separated

Occupation: _____

Religious Preference: _____

Advance Directive? ☐ Yes ☐ No
If Yes, Date: _____

Educ.: ☐ JHS ☐ HS ☐ College

☐ Other _____

Signature: _____ Date: _____