First Care Medical Centers, P. A.
12995 S. Cleveland Ave #184
Fort Myers, Fl 33907

Full Name: _____

Date of Birth: ____/____/_____

Are you a winter resident: Y/N- State?_____

Please list ALL current medications and doses, as well as any over-the-counter supplements:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

List Allergies:

_____
_____
_____
_____
_____

Please List any Specialists that you see:

_____
_____
_____
_____

Please List any surgeries or hospitalizations and the year they occurred: _____

_____
_____
_____
_____

Substance Use	Yes	No	Amount
Tobacco			____packs/day
Alcohol			____drinks/week
Other substances			

Do you currently have, or in the past had any of the following?

	Yes	No	Date
Head injury			
Muscular disease			
Kidney disease			
Mental disorder			
Anxiety/depression			
Thyroid disorder			
Cancer: Type_____			
Chronic back pain			
Stroke/TIA/Paralysis			
Eye disorder			
Spinal injury or surgery			
High blood pressure			
Heart disease			
Lung problems (COPD/asthma)			
Diabetes			
Jaundice/Hepatitis			
Seizures/Epilepsy			
Digestive problems			
Sleep Apnea			
Dizziness/Fainting			

Any other past medical history not listed above:_____

_____
_____
_____
_____
_____
_____

Family History	Yes	No
Diabetes		
Asthma		
Hypertension (high blood pressure)		
Seizures		
Heart Problems		
High Cholesterol		
Mental Disorders		
Anxiety/depression		
Cancer Type:_____		

Signature: _____ Date:_____

Form Reviewed by: _____ Date: _____