THE BARRANCO CLINIC

160 East Lake Howard Drive Winter Haven, Florida 33881
Sebring Lakeland Lake Wales Haines City Clermont Ocoee

Phone (863) 299-1251 Fax (863) 299-7666

MEDICAL HISTORY

PATIENT NAME_____Today's Date:_____/_____/_____

Date of Birth:_____/_____/_____ Daytime Phone Number:____/_____/_____ Height.:_____ Weight:_____Sex: M F

Referred By:_____ Phone Number: ____/_____/_____ Primary Care Doctor: _____

PATIENT PAST MEDICAL HISTORY

	YES	NO
Asthma		
Hayfever (Allergic Rhinitis)		
Allergy Injections		
History of Allergy Testing		
Hypertension/Heart Disease		
Shortness of Breath (SOB)		
Wheezing		
Diabetes		
Eyes Problems or Twitching		
Facial Numbness		
Headaches		
Arm/Leg Weakness		
Neck Pain		
Back Ache		
Cancer		
Weight Loss		
Abdominal Pain		
Acid or GI Reflux		
Anemia/Bleeding Disorders		
Thyroid Disease		
Sleep Apnea		
Fallen in last Year		
If yes, Fallen 2 or more times or with injury		
Pneumonia Vaccine (ever)		
Influenza Vaccine		
Skin Disease		

Office Use Only: Reviewed and entered by:

_____**Date:** ____/____/_____

REVIEW OF SYSTEMS

Have you recently had or do you have any problem with:

	YES	NO
EARS		
Hearing Loss		
Pain		
Pressure		
Ringing		
Vertigo or Dizziness		
Noise Exposure		
Freq. Inf.		
Discharge		
Dysequilibrium		
NOSE		
Trauma		
Surgery		
Obstruction		
Discharge		
Post Nasal Drip (PND)		
Epistaxis (Nosebleed)		
Snoring		
Changes in Sense of Smell		
THROAT/LARYNX		
Difficulty Swallowing		
Frequent Infections		
Soreness		
Frequent Clearing		
Voice Changes		
Spitting Up Blood		
Changes in Sense of Taste		

FAMILY HISTORY

PLEASE CHECK ANY THAT APPLY or UNKNOWN____

	PARENTAL	SIBLING
Heart Disease		
Hypertension		
Diabetes		
Hearing Loss		
Asthma		
Cancer		
Bleeding Disorders		
Allergies		

SOCIAL HISTORY

Do you Smoke? _____No _____Yes

If yes, #_____ packs/day for _____years

Are you a Former Smoker? ___ Yes
Quit # of years _____

Coffee? _____ No _____Yes #_____cups per day

Alcohol? _____No _____Yes # per day_____

Do you use Recreational Drugs? _____No _____Yes

Are you: _____Married _____ Single _____Divorced

ARE YOU ALLERGIC TO ANY MEDICATIONS? PLEASE LIST BELOW.

1.
2.
3.
4.
5.

PLEASE USE THE BACK OF THIS SHEET TO RECORD YOUR CURRENT MEDICATIONS, PAST SURGICAL HISTORY AND ANY ADDITIONAL MEDICAL HISTORY .

PATIENT NAME:_____ Today's Date:_____

PLEASE LIST ALL MEDICATIONS

List all tablets, patches, drops, ointments, injections, etc. Include prescription, over-the-counter, herbal, vitamin, and diet supplement products. Also list any medicine you take only on occasion.

MEDICATION	**WHAT IS THE DIAGNOSIS FOR THIS MEDICATION ?**
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	
If you need additional space talk with Medical Assistant once you have been called back to a room.	**Check here if additional pages of medicine list attached [ ]**

PAST SURGICAL HISTORY

HAVE YOU HAD?	**YES**	**NO**
HIP REPLACEMENT		
KNEE REPLACEMENT		

OPERATION	DATE	OPERATION	DATE
1.		5.	
2.		6.	
3.		7.	
4.		8.	

Please use the space below for any additional medical history not included on the front

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