**Michael A. Zimmer, MD FACP**
**509 Jackson Street North**
**St. Petersburg, FL 33705-1419**
**727-820-7800 Fax 727-820-7801**

Name_____ Age_____ Date_____

Have you often experienced any of these symptoms in the last year?(please circle yes or no)

| | | | | | |
|---|---|---|---|---|---|
| Y | N | Significant weight loss | Y | N | Shortness of breath |
| Y | N | Loss of appetite | Y | N | Chest pain |
| Y | N | Fever/chills | Y | N | Palpitations |
| Y | N | Nausea/vomiting | Y | N | Pain on walking |
| Y | N | Diarrhea | Y | N | Loss of vision |
| Y | N | Chronic constipation | Y | N | Bleeding problems |

Please list ALLERGIES or SENSITIVIES to medication:

| MEDICATION | TYPE OF REACTION |
|---|---|
| 1._____ | _____ |
| 2._____ | _____ |
| 3._____ | _____ |
| 4._____ | _____ |

Please list all medications you are currently taking (include over-the-counter meds i.e. aspirin.

| | |
|---|---|
| 1._____ | 5._____ |
| 2._____ | 6._____ |
| 3._____ | 7._____ |
| 4._____ | 8._____ |

Have you ever been diagnosed with any of the following? (circle)

| | | | |
|---|---|---|---|
| Migraine | Heart Disorder | Diverticulitis | Bleeding Disorder |
| Stroke | Heart Attack | Circulation Problem | Alcoholism |
| Emphysema | High Blood Pressure | Aneurysm | Diabetes |
| Asthma | Ulcer | Kidney Disease | Thyroid Disorder |
| Tuberculosis | Gallstones | Prostate Trouble | Depression |
| Pneumonia | Intestinal Bleeding | Arthritis | Emotional Disorder |

Other:_____

Please list all major sickness or surgery you have undergone.

| HOSPITALIZED FOR SICKNESS | YEAR | SURGICAL PROCEDURE | YEAR |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |
| 6. | | | |

SOCIAL HISTORY/HABITS

Do you smoke now?_____ Did you ever smoke?_____ How much?_____
How many years? _____ When did you quit? _____
Do you drink alcohol?_____ If yes, how much per week?_____

FAMILY HISTORY

| | IF LIVING | | IF DECEASED | |
|---|---|---|---|---|
| Family | Age | Current Health | Age | Cause of Death |
| Father: | | | | |
| Mother: | | | | |
| Brothers: | | | | |
| | | | | |
| | | | | |
| | | | | |
| Sisters: | | | | |
| | | | | |
| | | | | |
| | | | | |
| Spouse: | | | | |
| Children: | | | | |
| | | | | |
| | | | | |
| | | | | |

WOMEN ONLY

Menstrual History: Age of onset_____ Date of last period_____
Pregnancy: Age at first pregnancy_____ Did you breast feed?_____
Number of pregnancies_____ Live Births_____ Miscarriages_____
Have you ever taken birth control pills or hormones?_____