**JOVE MEDICAL, INC.**
**3111 45th Street, Suite 3**
**West Palm Beach, FL 33407**
**Phone: (561) 420-8820**
**Fax: (561) 420-8822**
**Dr. Pedro A. Sanchez, D.O.**
**Deborah A. Collins, ARNP NP-C**

DATE: ____________________

NAME: ____________________ DOB: ____________

REASON FOR VISIT:

Primary Care Provider/Physician: ________________________________

***GENERAL MEDICAL HISTORY***

DO YOU HAVE ANY ALLERGIES TO MEDICATIONS? ☐ YES ☐ NO, PLEASE DESCRIBE: ________________________________

________________________________________________________________________

ARE YOU TAKING ANY PRESCRIBED OR OVER THE COUNTER MEDICATION OR SUPPLEMENTS? ☐ YES ☐ NO, PLEASE LIST / DESCRIBE:

________________________________________________________________________

HAVE YOU EVER HAD SURGERY? ☐ YES ☐ NO DATE:____________ DESCRIBE________________________________

________________________________________________________________________

***PERSONAL MEDICAL HISTORY***

| | | | |
|---|---|---|---|
| CANCER | ☐ YES | ☐ NO | TYPE: |
| DIABETES | ☐ YES | ☐ NO | |
| HEART DISEASE | ☐ YES | ☐ NO | |
| HEART ATTACK | ☐ YES | ☐ NO | AGE: |
| HIGH BLOOD PRESSURE | ☐ YES | ☐ NO | |
| STROKE | ☐ YES | ☐ NO | |
| HIGH CHOLESTEROL | ☐ YES | ☐ NO | |

PLEASE LIST & DESCRIBE ANY OTHER MEDICAL HISTORY:

________________________________________________________________________

________________________________________________________________________

***FAMILY MEDICAL HISTORY***

| | ALIVE? | AGE / AGE AT DEATH | MAJOR MEDICAL PROBLEMS: |
|---|---|---|---|
| MOM | Y / N | ______ | ______________________ |
| DAD | Y / N | ______ | ______________________ |

SIBLINGS WITH MAJOR MEDICAL PROBLEMS: AGE, DESCRIBE:

________________________________________

________________________________________

________________________________________

DO YOU SMOKE? ☐ YES ☐ NO PACKS PER DAY: _______ HOW MANY YEARS: _______ WOULD YOU LIKE TO QUIT? ☐ YES ☐ NO

DO YOU CONSUME ALCOHOL? ☐ YES ☐ NO ______# OF DRINKS PER ☐ DAY ☐ WEEK ☐ MONTH

DO YOU EXERCISE REGULARLY? ☐ YES ☐ NO # OF DAYS / WEEK ______ DURATION ________ ACTIVITIES: ____________________

WOULD YOU DESCRIBE YOU DIET AS: ☐ VERY HEALTHY ☐ HEALTHY ☐ SOMEWHAT HEALTHY ☐ FAIR ☐ POOR

☐ UNRESTRICTED ☐ LOW FAT ☐ LOW CHOLEST ☐ LOW SWEETS, CARBS ☐ LOW/NO DAIRY ☐ VEGETARIAN ☐ OTHER: _____________ ___

***GYN***

ARE YOUR PERIODS REGULAR? ☐ YES ☐ NO IF NO, DESCRIBE: ________________________________

ARE THEY PAINFUL? ☐ YES ☐ NO

ARE THEY HEAVY? ☐ YES ☐ NO DO YOU HAVE ANY BLEEDING BETWEEN PERIODS? ☐ YES ☐ NO

LENGTH OF PERIODS: ____________

DATE OF LAST PAP TEST: ______________ NORMAL? ☐ YES ☐ NO

DATE OF LAST MAMMOGRAM: ______________ NORMAL? ☐ YES ☐ NO

DATE OF LAST BONE DENSITY TEST: ______________ NORMAL? ☐ YES ☐ NO OSTEOPOROSIS? ___ OSTEOPENIA? ___

HAVE YOU EVER HAD AN ABNORMAL PAP TEST? ☐ YES ☐ NO HAVE YOU EVER HAD AN ABNORMAL MAMMOGRAM? ☐ YES ☐ NO

DESCRIBE ABNORMALITY AND PROCEDURES / DATE: ________________________________

# OF PREGNANCIES: _____ NUMBER OF BIRTHS: _____ MISCARRAIGES: _____ ABORTIONS: _____ DATE OF LAST PREGANCY: ______________