



JOVE MEDICAL
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 West Palm Beach, FL 33413
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 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

FAMILY MEDICAL HISTORY

	ALIVE? Y / N	AGE / AGE AT DEATH	MAJOR MEDICAL PROBLEMS:
MOM	Y / N	_____	_____ _____ _____
DAD	Y / N	_____	_____ _____ _____
SIBLINGS WITH MAJOR MEDICAL PROBLEMS: AGE, DESCRIBE: _____ _____ _____			

PLEASE LIST & DESCRIBE ANY OTHER MEDICAL HISTORY: _____

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 YOUR 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? ___ OSTEOGENIA? ___

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: _____