| E. Thomas Arne Jr., D.O., F.A.C.C.  1250 S. Tamiami Trail Suite 401  Sarasota, Florida 34239  Office: 941-366-2194 Fax: 941-366-7025  [www.gulfshorepc.com](http://www.gulfshorepc.com) |  |  | IMG_4682 |
| --- | --- | --- | --- |

**PATIENT MEDICAL HISTORY**

**(Please Print and Check All Applicable)**

**Page 1 of 7**

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_Age: \_\_\_\_\_\_\_

Usual Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_lbs. Current height \_\_\_\_\_\_\_\_\_\_\_\_\_\_Ft.

**AUTOIMMUNE**

|  |  |
| --- | --- |
|  | Arthritis |
|  | Gout |
|  | Multiple Sclerosis |
|  | Polymyalgia |
|  | Psoriasis |

**CARDIOVASCULAR**

|  |  |
| --- | --- |
|  | Hypertension |
|  | High Cholesterol |
|  | Heart Attack |
|  | Stent |
|  | Murmur |
|  | Heart Failure |
|  | Stroke/TIA |
|  | Arrhythmia |
|  | Atrial Fibrillation |

**PATIENT MEDICAL HISTORY (Continued)**

**(Please Print and Check All Applicable)**

**Page 2 of 7**

**NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CARDIOVASCULAR (CONTINUED)**

|  |  |
| --- | --- |
|  | Fainting Spells |
|  | Heart Valve Disease |
|  | Pacemaker/Defibrillator |

**ENDOCRINE**

|  |  |
| --- | --- |
|  | Diabetes |
|  | Osteoporosis |
|  | Thyroid Disorder |

**EARS NOSE THROAT (ENT)**

|  |  |
| --- | --- |
|  | Glaucoma |
|  | Cataracts |
|  | Hearing Loss |
|  | Macular Degeneration |
|  | Visual Problems |
|  | Diabetic Retinopathy |

**GASTROINTESTINAL**

|  |  |
| --- | --- |
|  | GERD |
|  | Peptic Ulcer |
|  | Crohn/Colitis/IBS |
|  | Hemorrhoids |
|  | Gallbladder Disease |
|  | Colon Cancer |
|  | Colon Polyps |
|  | Pancreatitis |
|  | Cirrhosis |
|  | Diarrhea |

**PATIENT MEDICAL HISTORY (Continued)**

**(Please Print and Check All Applicable)**

**Page 3 of 7**

**NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**GASTROINTESTINAL (CONTINUED)**

|  |  |
| --- | --- |
|  | Constipation |
|  | Diverticulosis/Diverticulitis |
|  | Eating Disorder |
|  | Hiatal Hernia |
|  | H. Pylori |
|  | Hepatitis |
|  | ABNL Liver Function |

**CANCER**

|  |  |
| --- | --- |
|  | Type: |
|  | Lymphoma |
|  | History of Radiation |

**GENITOURINARY**

|  |  |
| --- | --- |
|  | Urinary Tract Infection |
|  | Venereal Disease (STD’S) |
|  | Abnormal Pap |
|  | Enlarged Prostate (BPH) |
|  | Kidney Disease |
|  | Kidney Stones |
|  | Urinary Incontinence |

**HEMATOLOGY**

|  |  |
| --- | --- |
|  | Anemia |
|  | Bleeding Disorder |
|  | Blood Transfusion |

**PATIENT MEDICAL HISTORY (Continued)**

**(Please Print and Check All Applicable)**

**Page 4 of 7**

**NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**INFECTIOUS DISEASE**

|  |  |
| --- | --- |
|  | Herpes |
|  | HIV |
|  | Lyme Disease |
|  | Positive Tuberculosis Test (TB) |
|  | Tuberculosis |
|  | Pneumonia |

**MUSCLE SKELETAL**

|  |  |
| --- | --- |
|  | Arthritis |
|  | Fractures Type(Print): |
|  | Muscle Spasm’s /Cramps |
|  | Spinal Stenosis |
|  | Spine Disc Disease(Print location): |
|  | Tendonitis |

**NEURO/MENTAL HEALTH**

|  |  |
| --- | --- |
|  | Anxiety |
|  | ADHD |
|  | Alzheimer |
|  | Bipolar |
|  | Balance Problems |
|  | Chronic Fatigue |
|  | Dementia |
|  | Depression |
|  | Epilepsy/Seizures |
|  | Memory Loss |
|  | Obsessive Compulsive Disorder (OCD) |
|  | Parkinson’s |
|  | Sleep Disorder |
|  | Tremor |

**PATIENT MEDICAL HISTORY (Continued)**

**(Please Print and Check All Applicable)**

**Page 5 of 7**

**NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PULMONARY**

|  |  |
| --- | --- |
|  | Asthma |
|  | Bronchitis |
|  | Chronic Obstructive Pulmonary Disease(COPD) |
|  | Sleep Apnea |

**Please list the date you most recently had the following services/tests completed.**

**DATE SERVICE/TEST COMPLETED**

|  |  |
| --- | --- |
|  | Abdominal Aortic Ultrasound |
|  | Annual Physical |
|  | Bone Density |
|  | Cardiac Catheterization |
|  | Carotid Ultrasound |
|  | Chest X-ray |
|  | Colonoscopy |
|  | Echocardiogram |
|  | EKG |
|  | EYE Exam |
|  | Hearing Test |
|  | Stool Culture |
|  | Mammogram |
|  | Mini Mental Status Exam |
|  | Pap Smear |
|  | PSA |
|  | Spirometry (Breath Test) |
|  | Stress Test |
|  | Tuberculosis Test (TB) |
|  | Upper Endoscopy |

**PATIENT MEDICAL HISTORY (Continued)**

**Page 6 of 7**

**NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please list the names of any other doctors or specialists that you see:**

**REASON DR. NAME (Please Print)**

|  |  |
| --- | --- |
| Allergy |  |
| Cardiology |  |
| Dermatology |  |
| Gastro |  |
| OB/GYN |  |
| Hematology |  |
| Neurology |  |
| Nephrology |  |
| Oncology |  |
| Ophthalmology |  |
| Orthopedics |  |
| Otolaryngology (ENT) |  |
| Pain Management |  |
| Podiatry |  |
| Pulmonology |  |
| Psychiatry |  |
| Urology |  |
| Other |  |

**ADULT IMMUNIZATION HISTORY**

**Immunization Date Received Not Immunized**

|  |  |  |
| --- | --- | --- |
| Hepatitis A |  |  |
| Hepatitis B |  |  |
| Influenza |  |  |
| Pneumococcal |  |  |
| Meningococcal |  |  |
| Chicken Pox/Shingles |  |  |

**PATIENT MEDICAL HISTORY (Continued)**

**Page 7 of 7**

**NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ALLERGIES OR INTOLERANCES**

|  |  |  |
| --- | --- | --- |
| **Do you have any allergies or intolerances?** | **Yes** | **No** |

**List Allergies or Intolerances:**

|  |
| --- |
|  |
|  |
|  |
|  |
|  |

**FAMILY HEALTH CONDITIONS**

**Please List any Health Conditions and Date of Death if Applicable.**

**CONDITIONS DATE OF DEATH**

|  |  |  |
| --- | --- | --- |
| Mother |  |  |
| Father |  |  |
| Siblings |  |  |