FIRST COAST
INFECTIOUS DISEASE CONSULTANTS
THE CARE AND EXPERTISE YOU DESERVE

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Initial History Form

Welcome to **First Coast Infectious Disease Consultants, LLC**. In order for us to get to know you better and help you with any problem you might have, please fill out this health questionnaire to the best of your knowledge. If you are not sure, please mark the question with a question mark and we will discuss it with you at your appointment.

Name: _____ Date: _____
Age: _____ Date of Birth: _____ Height: _____ inch Weight: _____ lbs.

Who is your primary provider? Name: _____
(Family or primary doctor) Address: _____
_____
Who referred you to our clinic? Name: _____
(If different from above) Address: _____
_____
To whom do you want us to send results?
Name: _____
Address: _____
_____

If we try to reach you, may we leave a message on your voice mail/answering machine?
☐ No ☐ Yes, preferred number: (____) ____ - ____ x _____

In your own words, why are you here to see an Infectious Diseases physician?
_____
_____
_____

What medications are you taking (including vitamins, herbs, over-the-counter pills)?

Name of Drug	Dose	Taken how often?	For what purpose (diagnosis)

Have you ever had allergies to medications? ☐No ☐Yes

Drug	Reaction	Drug	Reaction

Please list all of your Surgeries and Hospitalizations

Surgery, Hospitalization	Dates (approx)	Where treated

Have you had these vaccinations?

Vaccine	Last date	Vaccine	Last date
Pneumovax		Hepatitis A	
Influenza		Hepatitis B	
Tetanus (TDAP)		Chickenpox or Shingles	

Sexuality

Do you consider yourself? ☐Heterosexual ☐Homosexual ☐Bisexual ☐Transsexual
Are you married/committed? ☐Yes ☐No ☐Divorced ☐Separated ☐Widowed
Do you have a steady sexual partner? ☐ Yes ☐ No
Have you had sex in the past three months? ☐ Yes ☐ No
Do you use condoms? ☐ Never ☐ Sometimes ☐ Always
How many sexual partners have you had in the past 3 months? _____

Substance Use

Do you smoke cigarettes? Never ☐No longer use, quit ____ Yes, average _____cigs/day

How old were you when you started smoking? _____
Do you drink alcohol? Never ☐ No longer use, quit ____ Yes, average_____drinks/day
Did you ever have an alcohol blackout? ☐ Yes ☐ No
Did you ever have a DUI? ☐ Yes ☐ No
Do you use Marijuana? Never ☐ No longer use, quit ____ Yes ☐ How often?_____
Do you use Cocaine? Never ☐ No longer use, quit ____ Yes ☐ How often? _____
Do you use Heroin? Never ☐ No longer use, quit ____ Yes ☐ How often? _____
Do you use Crystal Meth? Never ☐ No longer use, quit ____ Yes ☐ How often?_____
Have you ever injected IV drugs? ☐ Yes ☐ No

Are you experiencing significant problems or do you have concerns with any of the following?

No	Yes	General	Comments	No	Yes	EENT	Comments
		Weight loss				Blurred or bad vision	
		Weight gain				Spots before eyes	
		Fever or chills				Pain in eyes	
		Night sweats				Hoarseness	
		Problems with wound healing				Thrush	
		Increasing weakness, fatigue				Mouth sores	
		Dizziness				Difficulty hearing	
		Intolerance to heat or cold				Frequent nose bleeds	
		Poor appetite				Frequent sinus problems	

No	Yes	Respiratory	Comments	No	Yes	Cardiovascular	Comments
		Cough				Chest pain/discomfort	
		Wheezing/Asthma				Need to sleep head up	
		Sputum production				Irregular heartbeat	
		Shortness of breath				Fainting spell	
		Hx of exposure to tuberculosis				Swelling of feet/legs	
		Prior TB skin test (PPD)				High blood pressure	
		Hx of positive PPD				High cholesterol	
		Rheumatic heart disease					
		Heart murmur					

No	Yes	Gastrointestinal	Comments	No	Yes	Genitourinary	Comments
		Nausea/vomiting				Frequent urination	
		Vomiting blood				Painful urination	
		Blood in stools				Difficulty holding urine	
		Black/tarry stools				Decreased stream	

		Difficulty swallowing				Blood in urine	
		Indigestion/Heartburn				Penile/vaginal discharge	
		Abdominal pain				Frequent vaginal yeast	
		Diarrhea				Sores/lesions genitals	
		Constipation				Pain/masses breasts	
		Hemorrhoids				Nipple discharge	
		History of hepatitis					

No	Yes	Musculoskeletal/Skin	Comments	No	Yes	Endocrine	Comments
		Joint pain/swelling				Low thyroid (Hypo-)	
		Body ache/muscle cramps				High thyroid (Hyper-)	
		Morning stiffness				Diabetes	
		Itching				Excessive thirst	
		Rash				Change in breast size	
		Skin problems				Change in body hair	
		Easy bleeding				Decreased interest in sex	
		Nail problems				Problems with erection	

No	Yes	Neurologic	Comments	No	Yes	Psychiatric	Comments
		Seizures				Depression	
		Headache				Anxiety	
		Tingling/numbness				Often feeling sad	
		Weakness on one side				Spontaneous crying	
		Vertigo/balance problems				Less interest in usual activities	
		Sleep disturbances				Feelings of decreased self worth	
						Hallucinations	
						Previous psychiatrist/therapist?	

Gynecologic History

Age when 1st period occurred: _____ Age at menopause: _____
No. of pregnancies: ____ No. of children: ____ No. of miscarriages: ____ No. of abortions: ____
Interval between periods (days): ____ Duration of periods (days): ____
Date of last period ____/____/_____ Are/were your periods regular? ☐ Yes ☐ No
Last PAP smear (MM/YY) ____/_____ Date of last mammogram ____/_____
Result: _____ Result: _____
STD history: ☐ None

Have you had any of the following? If so when were you treated?

Syphilis	Herpes simplex
Gonorrhea	PID
Chlamydia	Genital warts

Is there anything else we need to know?

_____
_____
_____
_____
_____
_____

Patient Signature: _____ Date: _____