LANGER FAMILY MEDICINE, P.A.
1806 Short Branch Drive, Suite 101
Trinity, FL 34655-4426
Phone: (727) 372-0873 Fax: (888) 402-1685

Name:_____ Date:_____

Reason for today's visit:_____

Previous care provided by:_____

How did you hear about our practice?_____

IN the past 2 weeks, have you been bothered by: Little interest or pleasure in doing things? Y / N
Feeling down, depressed or hopeless? Y / N

Review of Symptoms: Please circle any persistent symptoms you have had the past few months. Read through every section and circle "No problems" if none of the symptoms apply to you.

General
Unexplained weight loss / gain
Unexplained fatigue / weakness
Fall Asleep during the day when sitting
Fever / Chills
No problems

Skin
New or change in mole
Rash / Itching
No problems

Breast
Breast lump
Pain
Nipple discharge
No problems

Ear/Nose/Throat
Nosebleeds
Trouble swallowing
Sore throat or hoarseness
Hearing loss
Ringing in ears
No problems

Endocrine
Heat or cold sensitivity
No problems

Cardiovascular
Chest pain
Palpitations
No problems

Eyes
Change in vision
Eye pain
Redness
No problems

Respiratory
Cough
Wheeze
Snoring
Shortness of breath
Altered breathing during sleep
No problems

Gastrointestinal
Heartburn / Reflux
Indigestion
Blood in stool
Constipation
No problems

Musculoskeletal
Neck pain
Back pain
Muscle / Joint pain
No problems

Genitourinary
Leaking urine
Blood in urine
Nighttime urination
Frequent urination
Discharge: penis / vagina
Sexual function
No problems

Hematologic / Lymphatic
Swollen glands
Easy bruising
No problems

Neurological
Headache
Memory loss
Fainting
Dizziness
Numbness / Tingling
Unsteady gait
Frequent falls
No problems

Allergic / Immune
Hay fever
Allergies
Frequent infections
No problems

Psychiatric
Anxiety
Stress
Irritability
Lack of concentration
No problems

Women only
Pre-menstrual symptoms
Problem with menstrual periods
Hot flashes
Night sweats
No problems

Immunizations: Circle any Vaccinations you have had and list the year if known.

Tetanus	**Tetanus w/ Pertussis**	**Varicella**
Pneumovax	**Prevnar**	**Influenza**
MMR	**Meningitis**	**Zostavax**
Hepatitis A	**Hepatitis B**	**HPV**

Personal Information:

First Name:	**Last Name:**	**MI:**	**DOB:**
Address:	**City:**	**ST:**	**ZIP:**
Home Phone:	**Work Phone:**	**Cell Phone:**	
Other Names Used:		**E-mail:**	
Gender:	**SSN:**	**Language:**	**DL:**
Marital Status:	**Ethnicity:**	**Race:**	
Previous PCP:		**Phone:**	

Emergency Contact:

First Name:	**Last Name:**	**MI:**	**DOB:**
Address:	**City:**	**ST:**	**ZIP:**
Home Phone:	**Work Phone:**	**Cell Phone:**	

Pharmacy Information:

Name:		**Phone:**	**Fax:**
Address:	**City:**	**ST:**	**ZIP:**

Advanced Directive: Circle all that apply, and provide copies for our records.

Do Not Resuscitate	**Durable Power of Attorney**	**Living Will**	**HC Proxy**

I / we do hereby consent to and authorize the performance of all treatments, surgeries and medical services deemed advisable by the physicians and staff of Langer Family Medicine, PA to me or to the above-named minor of whom I am the parent or legal guardian. I hereby certify that to the best of my knowledge, all statements contained hereon are true. I understand that I am directly responsible for all charges incurred for medical services for myself and my dependents regardless of insurance coverage. I furthermore agree to pay legal interest, collection expenses, and attorneys' fees incurred to collect any amount I may owe. I also hereby authorize Langer Family Medicine, PA to release information requested by insurance companies and / or its representatives. I fully understand this agreement and consent will continue until canceled by me in writing.

Signature of Patient / Responsible Party:_____ **Date:**_____

Name of Patient / Responsible Party:_____ **Relationship:**_____

Medication: List all medications you are currently taking, including both prescription and non-prescription, and the dosage.

Medication	Dosage

Medication Allergies: List all known medication allergies.

Medical History: Check if you have ever experienced the following conditions, and the year of onset.

Illness / Chronic Medical Condition	Year

Surgical History: List any surgeries you have had, and the year preformed.

Surgical Procedure	Year

GYN History

What age did you start having periods	
Date of menopause (if applicable)	
Last menstrual cycle	
Number of Pregnancies	
Date and Type of Delivery	
Any Complications during delivery	

Health Maintenance: Circle if you have received the following, and the date of most recent exam.

Exam / Procedure	Date
Colonoscopy	
Eye Exam	
Lipid Panel (Cholesterol)	
Physical / Wellness Exam	
DEXA Scan	
GYN Exam	
Mammogram	
Breast Exam	
PAP Test	

Family History: Circle all that apply, and list family member affected.

Condition	Family Member
Ovarian Cancer	
Breast Cancer	
Colon Cancer	
Cervical Cancer	
Prostate Cancer	
Melanoma	
Alzheimer's Disease	
Depression	
Diabetes	
Hypertension	
High Cholesterol	
Heart Disease	
Stroke	
Thyroid Disease	
Other	

Social History:

Occupation:		**Employer:**	
Children: Y ☐ N ☐	**How Many:**	**Male(s):**	**Female(s):**
Tobacco Use: Y ☐ N ☐	**Packs Per Day:**	**Year Quit:**	
Alcohol Use: Y ☐ N ☐	**How Often:**	**Type:**	
Exercise: Y ☐ N ☐	**Intensity:**	**Duration:**	
Caffeine Use: Y ☐ N ☐	**How Often:**	**Type:**	