INTERNAL MEDICINE & CLINICAL ANTI-AGING CENTER, LLC
FLORENDA L. FORTNER, M.D.
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Phone (727) 841-0700

Health History Questionnaire

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Patient Name: _____ **Date of Birth:** _____

Allergies: _____ **Age:** _____ ❑ New patient ❑ Established patient

Reason for today's visit?

_____

Previous Primary Care Physician:_____ Specialists you see: _____

Name of Medication	Strength	Daily Frequency

Pharmacy Name:	Phone #:	Address:

Mail away Pharmacy	Phone #:	Address:

Patient's Signature/ POA: _____ **Date:** _____

Physician's Signature: _____ **Date:** _____

Florenda L. Fortner, M.D.

Patient Name: _____ Date of Birth: _____

Medical History

Have you ever had or been diagnosed to have (check all that apply)

❑Alzheimer's disease
❑Anemia
❑Anxiety
❑Arthritis
❑Asthma
❑Atrial fibrillation
❑Bleeding disorder
❑Blood transfusion
❑Cancer (specify) _____
❑Cataracts
❑Colon Polyps
❑Depression
❑Diabetes
❑Fracture
❑Glaucoma
❑Heart attack
❑Heart Disease
❑Heart failure
❑Heart murmur
❑Heartburn
❑Hemorrhoids
❑High blood pressure
❑High cholesterol
❑Irritable bowel syndrome
❑Jaundice/ Liver Disease
❑Kidney Disease
❑Migraines/ Headaches
❑Osteopenia
❑Osteoporosis
❑Pneumonia
❑Prostate problems
❑Rheumatic fever
❑Seizures / epilepsy
❑Stroke
❑Syphilis
❑TB / Lung disease
❑ Thyroid disease
❑ Ulcers
❑ Urinary incontinence
❑ Other: _____

Health Maintenance
(List Date when last done)

❑ Bone Density Test _____
❑ Cholesterol Screen _____
❑ Colonoscopy _____
❑ Diabetes Screen _____
❑ Eye Exam _____
❑ Flu Vaccine _____
❑ HIV Testing _____
❑ Mammogram _____
❑ Pap smear _____
❑ Pneumonia Vaccine_____
❑ PSA _____
❑ Shingle Vaccine _____
❑ Tetanus Vaccine _____

Patient's Signature/ POA:
Date:

Physician's Signature & Date: