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

Social History

Patient's Name: Date of Birth:

Do you currently work? ❑ Yes ❑ No Occupation: _____ Retired? ❑ Yes ❑ No

Do you drink alcohol? ❑Yes ❑ No If yes, what kind? _____ If Yes, how many drinks per day? _____

Do you Smoke? ❑ Yes ❑ No How many packs per day? _____ How many years did you smoke? _____
Former Smoker? ❑ Yes ❑ No when did you quit? _____
Never Smoked ❑ Smoke rarely/occasionally ❑ Current every day smoker ❑ Current some day smoker ❑
Are you interested in quitting? ❑ Yes ❑ No

Caffeine intake:
❑ None ❑ Coffee ❑ Tea ❑ Cola Number of cups per day? _____

Diet: Are you dieting? ❑ Yes ❑ No What type of Diet Plan are you on? _____

Exercise:
❑ Sedentary (No Exercise)
❑ Mild exercise
❑ Occasional exercise
❑ Regular vigorous exercise

Do you currently use recreational drugs? ❑ Yes ❑ No

Are you sexually active? ❑ Yes ❑ No

Do you live alone? ❑ Yes ❑ No

Do you have frequent falls? ❑ Yes ❑ No

Do you have vision or hearing loss? ❑ Yes ❑ No

Do you feel Depressed? ❑ Yes ❑ No are you under a lot of stress? ❑ Yes ❑ No

Do you have panic attacks? ❑ Yes ❑ No Do you cry frequently? ❑ Yes ❑ No

Do you have trouble sleeping? ❑ Yes ❑ No

Do you have an Advanced Directive or Living Will? ❑ Yes ❑ No (Please provide us with copies)

Do you have a Durable Power of Attorney? ❑ Yes ❑ No Name & # _____

Patient's Signature or POA: _____ Date: _____

Physician's signature: _____ Date: _____