



Brain Fitness Centers OF FLORIDA

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Name: _____ Date: _____

Address: _____ DOB: _____ Age: _____

City: _____ State: _____ Social Security#: _____

Zip Code: _____ Telephone #: _____ Cell #: _____

Occupation: _____ Work Telephone #: _____

Spouse's Name: _____ E-Mail: _____

Physician's Name: _____ Date of last visit: _____ Referred by: _____

PRESENT MEDICATIONS: Including vitamins, tonics, over the counter medications, pain and sleeping pills, antacids, birth control pills, aspirin, Tylenol, cold remedies and laxatives.

PAST MEDICAL HISTORY – Do you have, or have you had any of the following?

| | <u>DATE</u> | | <u>DATE</u> |
|---------------------|-------------|---------------------------|-------------|
| High Blood Pressure | _____ | Tuberculosis | _____ |
| Heart Trouble | _____ | Positive TB test | _____ |
| Heart Attack | _____ | Diabetes | _____ |
| Rheumatic Fever | _____ | Thyroid Problems | _____ |
| Anemia | _____ | Arthritis | _____ |
| Stroke | _____ | Hepatitis | _____ |
| Cancer | _____ | Gallbladder trouble | _____ |
| Venereal Disease | _____ | Bladder Infections | _____ |
| Colitis | _____ | Other | _____ |
| Peptic Ulcer | _____ | Women: | |
| Hiatal Hernia | _____ | Age started menstruation: | _____ |
| Epilepsy | _____ | Last menstrual period: | _____ |
| Head Injury | _____ | Number of pregnancies: | _____ |
| Chronic Bronchitis | _____ | Cesarean Sections: | _____ |
| Emphysema | _____ | Number of miscarriages: | _____ |
| Asthma | _____ | Abortions: | _____ |

PAST SURGICAL HISTORY

| | <u>DATE</u> | | <u>DATE</u> |
|-------------|-------------|-----------------|-------------|
| Eyes | _____ | Prostate | _____ |
| Ears | _____ | Womb (Uterus) | _____ |
| Nose | _____ | Hysterectomy | _____ |
| Throat | _____ | Ovary | _____ |
| Thyroid | _____ | Appendectomy | _____ |
| Tonsils | _____ | Chest | _____ |
| Skin | _____ | Heart | _____ |
| Hip | _____ | Spine | _____ |
| Breast | _____ | Varicose Veins | _____ |
| Gallbladder | _____ | Kidney | _____ |
| Hernia | _____ | Bladder repair | _____ |
| Hemorrhoids | _____ | Exploratory | _____ |
| Stomach | _____ | Plastic Surgery | _____ |
| Colon | _____ | Fractures | _____ |
| Rectum | _____ | | |

Any other operations:

HEALTH MAINTENANCE

| | <u>DATE</u> | | <u>DATE</u> |
|----------------------|-------------|------------------------|-------------|
| Last pap smear | _____ | Colonoscopy | _____ |
| Last TB skin test | _____ | Last Pneumonia Vaccine | _____ |
| Last tetanus booster | _____ | Last Flu Vaccine | _____ |
| Last mammogram | _____ | Shingles Vaccine | _____ |
| Stool Cards | _____ | | |

Please list any medication, food, dust and/or pollen that you are allergic to: _____

What type and quantity of exercise and/or activity do you get regularly? _____

SOCIAL HISTORY

Home State: _____

Marital Status: **Single** **Married** **Widowed** **Separated** **Divorced**

Have you ever smoked? **YES** **NO** How many years? _____

Do you drink alcoholic beverages? **YES** **NO**

How much per day or week now? _____ Per Day _____ Per Week

Career/Previous Career: _____

Highest Level of Education Achieved _____

Diet Restrictions _____

Occupational Exposure _____

Any International Travel within the last 3 years _____

FAMILY HISTORY

| | <u>AGE</u> | <u>ALIVE</u> | <u>AGE AT DEATH</u> | <u>BASIC MEDICAL PROBLEMS</u> |
|----------|------------|--------------|---------------------|-------------------------------|
| Mother | _____ | _____ | _____ | _____ |
| Father | _____ | _____ | _____ | _____ |
| Brothers | _____ | _____ | _____ | _____ |
| Sisters | _____ | _____ | _____ | _____ |
| Children | _____ | _____ | _____ | _____ |

Do any of the following run in the family?

| | <u>YES</u> | <u>WHO</u> | | <u>YES</u> | <u>WHO</u> |
|---------------------|------------|------------|-------------------|------------|------------|
| High Blood Pressure | _____ | _____ | Tuberculosis | _____ | _____ |
| Heart Trouble | _____ | _____ | Kidney Disease | _____ | _____ |
| Strokes | _____ | _____ | Epilepsy | _____ | _____ |
| Emphysema | _____ | _____ | Bleeding Disorder | _____ | _____ |
| Diabetes | _____ | _____ | Cancer | _____ | _____ |
| Thyroid/Goiter | _____ | _____ | | | |

