EXCEPTIONAL CARE CENTER

Melissa Launder, MD
1810 Wellness Lane
Trinity, FL 34655
727-232-9780 (office)
727-232-9748 (fax)

Name:_____

Date:_____

New Patient History (Adult)

PATIENT INFORMATION

Date: _____

Name: _____ _____
First / Last / Middle Initial *Home Phone* *Day Phone* *Cell Phone*

Address		Date of Birth	
City/State		Gender	
Zip			
Email			
Alternate Home Address			

Emergency Contact	
Name	
Phone	

Local Pharmacy	
Name	
Location/Address	

How Did You Hear About Us?	
Name or Source	

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Name:_____

Date:_____

Please list the reasons for your visit today:

1	4
2	5
3	6

Please list any allergies to medications, dyes, or food:

Allergies:	

Please list any medications you are taking (including supplements):

Medication Name	Dose/Strength	How Often / Frequency	Need Refill?
			❑ Yes
			❑ Yes
			❑ Yes
			❑ Yes
			❑ Yes
			❑ Yes
			❑ Yes
			❑ Yes
			❑ Yes
			❑ Yes
			❑ Yes
			❑ Yes
			❑ Yes
			❑ Yes
			❑ Yes
			❑ Yes

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PAST MEDICAL HISTORY

Have you had or been diagnosed to have (please "X" all that apply)

	History		History		History
❑	Anorexia/Bulimia	❑	Heart Murmur	❑	Varicose Veins
❑	Anemia	❑	Hemorrhoids	❑	Ulcers
❑	Arthritis	❑	Hepatitis	❑	Alcohol Abuse
❑	Asthma	❑	Herniated Disc	❑	Substance Abuse
❑	Bleeding Disorder	❑	High Blood Pressure	❑	Kidney Stones
❑	Blocked Arteries	❑	High Cholesterol	❑	Meningitis
❑	Blood Clots	❑	High Triglycerides	❑	Obesity
❑	Bronchitis	❑	Thyroid Disorder	❑	Osteopenia
❑	Cancer: _____	❑	Inflammatory Bowel Disease	❑	Peripheral Vascular Disease / Poor Circulation
❑	Cataracts	❑	Insomnia	❑	Pneumonia
❑	Chronic Constipation	❑	History of Blood Transfusion	❑	Prostate Problems
❑	Colon Polyps	❑	Irritable Bowel Syndrome	❑	Rheumatic Fever
❑	COPD	❑	Kidney Disease	❑	Seasonal Allergies
❑	Macular Degeneration	❑	Glaucoma	❑	Seizures
❑	Degenerative Disc Disease	❑	Gout	❑	Sleep Apnea
❑	Diabetes / Pre-Diabetes	❑	Headaches	❑	Stroke
❑	Diverticulitis	❑	Heart Attack	❑	Tuberculosis
❑	Emphysema	❑	Heart Failure	❑	Gallstones
❑	Frequent Urinary Infections	❑	GERD/Heart Burn	❑	Other:
X	**Surgery/Procedure**	**X**	**Surgery/Procedure**	**X**	**Surgery/Procedure**
❑	Appendectomy	❑	Hernia Repair	❑	Other:_____
❑	Tonsillectomy	❑	Kidney Stones	❑	Other:_____
❑	Cardiac Bypass (CABG)	❑	Prostate Removal	❑	Other:_____
❑	Cardiac Stent	❑	C-Section		
❑	Knee Surgery	❑	Tubal Ligation		
❑	Hip Surgery	❑	Uterus Removal		
❑	Back Surgery	❑	Ovaries Removal		
❑	Eye Surgery:_____	❑	Lumpectomy		

Please list any other doctors involved in your care

Name/Specialty	Name/Specialty

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MEDICAL HISTORY CONTINUED

Please list all hospitalizations:
None: ❑

Hospital	Date	Reason
1)		
2)		
3)		
4)		

Please record the test/vaccine done and date last performed:

Physical Exam	❑	Year:		Flu Vaccine	❑	Year:
Eye Exam	❑	Year:		Pneumonia Vaccine	❑	Year:
Hearing Exam	❑	Year:		Tetanus Diphtheria	❑	Year:
Prostate Exam (male)	❑	Year:		TdaP	❑	Year:
Pap Smear (female)	❑	Year:		Shingles Vaccine	❑	Year:
Mammogram (female)	❑	Year:		Hep A Vaccine	❑	Year:
Diabetes Screen	❑	Year:		Hep B Vaccine	❑	Year:
Cholesterol Screen	❑	Year:		HPV Vaccine	❑	Year:
EKG	❑	Year:		MMR	❑	Year:
Cardiac Stress Test	❑	Year:		Meningitis Vaccine	❑	Year:
Bone Density	❑	Year:		Other:	❑	Year:
Colonoscopy	❑	Year:		Other:	❑	Year:
Positive PPD	❑	Year:		Other:	❑	Year:
HIV Test	❑	Year:		Other:	❑	Year:

Women's Health:

Menstrual Period ❑N/A	Most Recent Period Date:_____ ❑ Normal ❑ Light ❑Heavy Duration (days):_____	Birth Control ❑N/A		Method: _____
Periods ❑N/A	Regular: ❑Yes ❑No Avg. Days Apart:_____ Age at Onset:_____	Pregnancies ❑N/A		Total Pregnancies:_____ Total Full-Term Births:_____ Total Premature Births:_____ Abortions – Induced:_____ Abortions – Spontaneous:_____ Ectopic Pregnancies:_____ Multiple Births:_____
Menopause ❑N/A	Age at Onset:_____	Abnormal Pap Smears?	❑	Describe:_____

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Please list any blood relatives with health problems and causes of death (if applicable).

Example Health Problems: Aneurysms, Arthritis, High Blood Pressure, Heart Problems, High Cholesterol, Lung Problems, Gout, Stroke, Seizure/Epilepsy, Breast Cancer, Skin Cancer, Ovarian Cancer, Colon Cancer, Prostate Cancer, Diabetes, Kidney Disease, Thyroid Problems, Osteoporosis, Bleeding Problems, Allergies/Asthma, Mental Health Issues, Tuberculosis

Adopted ❑		Blood relative history unknown ❑ (you may skip form)		
	No History	Deceased?	Age or Age at Death	Health Problems
Father	❑	❑		
Mother	❑	❑		
Father's Father	❑	❑		
Mother's Father	❑	❑		
Father's Mother	❑	❑		
Mother's Mother	❑	❑		
Brother	❑	❑		
Brother	❑	❑		
Sister	❑	❑		
Sister	❑	❑		
Children	❑	❑		
Children	❑	❑		
Children	❑	❑		
Children	❑	❑		
Other	❑	❑		
Other	❑	❑		

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Social History *(Several questions below are of a personal nature but help the doctor better assess your health status and risks. Please answer to your comfort level. Your responses are confidential)*

Marital Status	❑Single ❑Married ❑Divorced ❑Widowed ❑Other:
Occupation	❑Full-time ❑Part-time ❑Retired
Education Level	❑High School ❑College ❑Graduate ❑Post-Graduate ❑Other:
Hobbies/Interests	
Exercise	Regularly Exercise? ❑Yes ❑No If Yes, what type:
Number of Children	
Number of Persons in Household	
Living Arrangement	❑House ❑Apartment ❑Condo ❑Dorm ❑Other:
Do You Feel Safe in Your Home Environment?	❑Yes ❑No if No, please describe:
Any History of Abusive Relationships?	❑Yes ❑No if Yes, please describe:
Do You Drink Alcohol?	❑Yes ❑No if Yes, what type and how frequently:
Do You Use Recreational Drugs?	❑Yes ❑No if Yes, what type and how frequently:
Have You Ever Smoked?	❑Yes ❑No If Yes, do you still smoke: ❑Yes ❑No If you still smoke, how many cigarettes a day: _____ How many years have you smoked:_____ If you recently stopped smoking, when did you quit:_____
Are you on a Special Diet?	❑Vegetarian ❑Diabetic ❑Low Salt ❑ Low Fat ❑Low Carb ❑Other:
Do you use Caffeine?	❑Yes ❑No If Yes, how much per day:
Do you have any sleeping problems?	❑Yes ❑No
Do you have a high level of stress?	❑Yes ❑No
Do you feel down, depressed, or hopeless?	❑Yes ❑No
Do you lack interest or pleasure in doing things you used to?	❑Yes ❑No
Are you sexually active?	❑Yes ❑No First active at age:_____ Current # of partners: _____ Total # of sexual partners:_____ Self-Described Orientation:_____ Do you use contraception: ❑Yes ❑No If Yes, what type:_____
Do you have a spiritual preference?	❑Yes ❑No if Yes, please describe:_____

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SYSTEMS REVIEW

Within the last 10 days, have you experienced any of the following? Please "X" any that apply.

	General		Cardiovascular		Urinary
❑	Recent Fever	❑	Abnormal / Irregular Heart Beat	❑	Pain/Burning with Urination
❑	Excessive Fatigue	❑	Chest Pain	❑	Frequent Urination
❑	Unexplained Weight Loss or Gain	❑	Awaken at night with Breathing Problems	❑	Blood in Urine
	Eyes	❑	Passing Out	❑	Trouble Starting to Urinate
❑	Discharge	❑	Shortness of Breath	❑	Waking Up to Urinate
❑	Pain or Burning	❑	Swelling of Ankles	❑	Leakage of Urine
❑	Blurred Vision	❑	Leg Pain While at Rest	❑	Change in Stream
❑	Loss of Sight	❑	Leg Pain While Walking		Musculoskeletal
❑	Itching or Watering		Gastrointestinal	❑	Joint Pain
	Ears	❑	Unable to Eat Certain Foods	❑	Joint Stiffness
❑	Hearing Loss	❑	Loss of Appetite / Weight	❑	Muscle Soreness
❑	Ringing	❑	Food Sticks in Throat		Skin
❑	Earache	❑	Painful Swallowing	❑	Change in Nails
❑	Feeling of Ear Fullness	❑	Heart Burn	❑	Lumps
	Nose and Sinuses	❑	Indigestion	❑	Recurrent Rashes
❑	Bleeding	❑	Nausea	❑	Sores that Bleed or Do Not Heal
❑	Nasal Congestion	❑	Vomiting Blood	❑	Change in Mole
❑	Sneezing	❑	Abdominal or Stomach Pain		Nervous System
❑	Loss of Sense of Smell	❑	Diarrhea	❑	Headaches
	Mouth and Throat	❑	Constipation	❑	Seizures / Convulsions
❑	Dry Mouth	❑	Recent Change in Bowel Habits	❑	Fainting Spells
❑	Soreness or Bleeding in Mouth Area	❑	Blood in Stools	❑	Frequent Memory Loss
❑	Sore Throat	❑	Black Stools	❑	Weakness
❑	Mouth Ulcers		Breast	❑	Shakiness or Tremor
❑	Hoarseness	❑	Pain	❑	Loss of Sensation / Numbness
❑	Dental Issues	❑	Lumps	❑	Feeling of Tingling in Limb
	Neck	❑	Nipple Discharge	❑	Speech Difficulty
❑	Pain		Reproductive - Women		Mental Health
❑	Lumps	❑	Irregular Periods	❑	Thoughts of Suicide
	Respiratory	❑	Spotting Between Periods	❑	Marital Problems
❑	Cough	❑	Vaginal Discharge / Burning / Itching	❑	Trouble Sleeping
❑	Coughing Up Blood	❑	Painful Periods	❑	Panic Attacks
❑	Shortness of Breath	❑	Pain / Trouble During Intercourse	❑	Anxiety
❑	Wheezing		Reproductive - Men	❑	Thoughts of Harming Others
❑	Snoring	❑	Discharge from Penis		Endocrine
	Blood Disorders	❑	Pain or Swelling of Testicles	❑	Unusual Intolerance of Heat
❑	Easy Bruising	❑	Pain / Trouble During Intercourse	❑	Unusual Intolerance of Cold
❑	Excessive Bleeding	❑	Problems with Erection	❑	Excessive Thirst
				❑	Excessive Hunger

Dr. Initials: _____