Access Family Care, LLC
Tazeen Zaidi, MD — Family Medicine

712 W 25th St, Sanford, FL 32771
Phone (407) 402-2303 • Fax (407) 322-6341
accessfamilycarefl@gmail.com

Patient Medical History Form

Please complete as thoroughly as possible. This information helps us provide safe, personalized care.

> **Please Note: Please print this completed form and bring it to your appointment. Do not return this form by email or upload it online.**

Patient Name *

Date of Birth *

Today's Date *

REASON FOR TODAY'S VISIT

Chief Complaint / Reason for Visit

ALLERGIES

List all medication, food, and environmental allergies and the reaction they cause. Write "NKDA" (No Known Drug Allergies) if none.

Allergen	Reaction

PRESCRIPTION HISTORY CONSENT

I hereby grant permission to Access Family Care, LLC to view my prescription history from external sources.

Signature

Date

CURRENT MEDICATIONS

Include prescription drugs, over-the-counter medications, vitamins, and supplements.

Medication Name	Dose	Frequency	Prescribing Provider

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MEDICAL HISTORY — CHECK ALL THAT APPLY

- ☐ NONE
- ☐ Allergies
- ☐ Asthma
- ☐ Cancer (type)
- ☐ Reflux
- ☐ Gout
- ☐ Hepatitis
- ☐ HIV
- ☐ Hypertension
- ☐ Kidney Disease
- ☐ Thyroid Disease
- ☐ Lupus
- ☐ Psychiatric Disorder
- ☐ Anemia
- ☐ COPD / Emphysema
- ☐ Hypothyroidism
- ☐ Migraine Headaches
- ☐ Seizure Disorder
- ☐ Stroke / TIA (history of)
- ☐ Arthritis
- ☐ Diabetes
- ☐ Heart Disease
- ☐ High Cholesterol
- ☐ Liver Disease
- ☐ Testosterone (Low)

Other / Cancer Type (Please Specify)

PREVIOUS SURGERIES

Have you undergone any of these surgical procedures? Check all that apply.

- ☐ Appendectomy
- ☐ Hysterectomy
- ☐ Thyroid Surgery
- ☐ Gallbladder
- ☐ Breast Surgery
- ☐ Joint Surgery
- ☐ Tonsillectomy
- ☐ Other

If Other, Please Specify

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FAMILY HISTORY

List any family members (parents, grandparents, aunts, uncles, siblings, and/or children) who have the following conditions.

Cancer

☐ Yes ☐ No

Type(s)

Relationship (Alive/Deceased)

Diabetes

☐ Yes ☐ No

Relationship (Alive/Deceased)

Heart Disease

☐ Yes ☐ No

Relationship (Alive/Deceased)

High Blood Pressure

☐ Yes ☐ No

Relationship (Alive/Deceased)

High Cholesterol

☐ Yes ☐ No

Relationship (Alive/Deceased)

Kidney Disease

☐ Yes ☐ No

Relationship (Alive/Deceased)

Thyroid Disease

☐ Yes ☐ No

Relationship (Alive/Deceased)

Other

☐ Yes ☐ No

Relationship (Alive/Deceased)

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SOCIAL HISTORY

Occupation

Marital Status

Tobacco Use:

☐ Never ☐ Former (quit date below) ☐ Current

Packs per Day / Quit Date (if applicable)

Alcohol Use:

☐ Never ☐ Occasional ☐ Regular

Drinks per Week (approx.)

Recreational / Non-Prescribed Drug Use:

☐ Never ☐ Former ☐ Current

Please Describe (substance, frequency)

IMMUNIZATIONS

Have you received any of the following vaccines? If yes, please list the approximate date received.

Influenza (Flu Vaccine)

Shingles

Pneumonia

HPV

Tetanus

Covid

Other

OB/GYN HISTORY (IF APPLICABLE)

Number of Pregnancies

Number of Children

Number of Miscarriages/Abortions

Are You Currently Pregnant or Could You Be Pregnant?

Date of Last Menstrual Period

Birth Control

Age of First Menses / Age of Menopause

SCREENINGS / PREVENTIVE HEALTH

Please list the date of your last screening exam, if applicable.

Colonoscopy

Mammogram

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Pap Smear

Prostate Exam

Bone Density

Date of Last Physical / Dental / Eye Exam

Other

Up to Date on Recommended Vaccinations? (Y/N, list any known)

PATIENT HEALTH QUESTIONNAIRE (PHQ-2)

Over the past two weeks, how often have you been bothered by any of the following problems?

Little interest or pleasure in doing things

☐ Not at all (0) ☐ Several days (1) ☐ More than half the days (2) ☐ Nearly every day (3)

Feeling down, depressed, or hopeless

☐ Not at all (0) ☐ Several days (1) ☐ More than half the days (2) ☐ Nearly every day (3)

PATIENT ATTESTATION

I certify that the information provided on this form is accurate and complete to the best of my knowledge. I understand that this information will be used by my care team to guide my diagnosis and treatment, and I will notify Access Family Care, LLC of any changes to my health history.

Patient / Guardian Printed Name *

Date *

Signature *

Date *