INFECTIOUS DISEASE CONSULTANTS

Infectious Diseases • HIV & Hepatitis • Wound Care • Travel Health • Outpatient Infusion

Main Office
685 Palm Springs Drive, Suite 2A
Altamonte Springs, Florida 32701
(407) 830-5577 • Fax (407) 830-4164

Name: ______________________________ Date: ____________________
Age:_______ Date of Birth:____________________ Sex:_______ Male ______ Female______

Who is your primary physician?____________________ Specialty ____________________

Who referred you to this office? ____________________ Specialty ____________________

What other physicians have you seen in the past?

Name	Specialty	Date of last visit

What is your reason for this visit?

____

Are you here for a hospital follow up? ☐ Yes ☐ No
If "yes"
What hospital ______________________________ When ____________________

Which physician (s) from the hospital saw you at the hospital? ____________________

Are you allergic to any medications?

Name of the drug	Type of reaction?

What medications are you currently taking?

Name of the drug?	When was it started?

Any recent vaccines or immunizations?

What type of vaccine?	When was it given?

Diplomats in Internal Medicine and Infectious Diseases
Fernando S. Alvarado, MD, MPH & TM, FACP • Jason C. Sniffen, DO, FACOI, FACP, FIDSA • Christopher D. Cooper, MD
Alexander Velazquez, MD • Javier E. Marinez, MD • Joseph T. Katta, DO • Luis Junco-Noa, MD
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SOCIAL HISTORY

Marital status: Single Married
Name of spouse of companion: ___________________

Do you have any children? Yes No
What type of work do you do? ___________________

Do you smoke? Yes No
Drink alcohol? Yes No Other Drugs? Yes No

Past Medical Problems

Name: ______________________________

Check (✓) conditions you have or have had in the past.

Condition			Condition			Condition		
Abdominal surgery	Yes	No	Chemotherapy	Yes	No	Gallbladder disease	Yes	No
Alcoholism	Yes	No	Chickenpox	Yes	No	Gout	Yes	No
Anemia	Yes	No	Chronic bronchitis	Yes	No	Heart attack, Angina	Yes	No
Anticoagulation	Yes	No	Chronic sinusitis	Yes	No	Heartbeat, Irregular	Yes	No
Appendicitis	Yes	No	Colitis Leg or foot ulcer	Yes	No	Heart failure, CHF	Yes	No
Arthritis	Yes	No	Cirrhosis	Yes	No	Heart murmur	Yes	No
Artificial joint	Yes	No	Connective tissue	Yes	No	Heart pacemaker	Yes	No
Asthma	Yes	No	COPD, Emphysema	Yes	No	Heart surgery	Yes	No
Blood clot legs, lung	Yes	No	Cystic fibrosis	Yes	No	Heart valve disease	Yes	No
Blood donation	Yes	No	Dementia	Yes	No	Hemorrhoids	Yes	No
Blood transfusion	Yes	No	Diabetes	Yes	No	Hepatitis, Jaundice	Yes	No
Bone infection	Yes	No	Diverticular disease	Yes	No	Herpes infection	Yes	No
Cancer	Yes	No	Drug addiction	Yes	No	High blood pressure	Yes	No
Cancer radiation	Yes	No	Endocarditis	Yes	No	Hysterectomy	Yes	No

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Condition		
HIV infection	Yes	No
Kidney disease	Yes	No
Kidney infection	Yes	No
Lyme disease	Yes	No
Lupus	Yes	No
Measles	Yes	No
Meningitis	Yes	No
Mononucleosis	Yes	No
Mumps	Yes	No
Non-healing wound	Yes	No
Pancreatitis	Yes	No
Paralysis	Yes	No
Parasitic infection	Yes	No
PID, Pelvic infection	Yes	No
Pneumonia	Yes	No
Positive PPD/TB. Test	Yes	No
Prostate problems	Yes	No
Psoriasis	Yes	No
Psychiatric illness	Yes	No
Rheumatic fever	Yes	No
Sarcoidosis	Yes	No
Seizures	Yes	No
Shingles, zoster	Yes	No
Skin infection	Yes	No
Splenectomy	Yes	No
Steroid treatment	Yes	No
Stomach ulcer	Yes	No
Stroke (CVA)	Yes	No
Suicidal attempt	Yes	No
Syphilis	Yes	No
Thyroid problems	Yes	No
Tonsillectomy	Yes	No
Tuberculosis	Yes	No
Urinary infections	Yes	No
Venereal disease	Yes	No
Other illness	Yes	No
Other surgeries	Yes	No

COMPLETE REVIEW OF 14 SYSTEMS

CONSTITUTIONAL:

Weight Loss___ Excess Fatigue ___ Chills ___ Fever ___ Night Sweats ___ Weakness ___ Anorexia ___

EYES:

Glasses/Contacts ___ Vision Changes ___ Diplopia ___ Blurred Vision ___ Pain ___ Discharge ___

Excessive Tearing ___ Date of Last Exam ___

ENT/MOUTH:

Earache ___ Tinnitus ___ Discharge ___ Hearing Loss ___ Popping ___ Stuffy Nose ___ Hoarseness ___

Mouth Breathing ___ Post-nasal Drip ___ Halitosis ___ Swelling ___ Sore Throat ___ Bleeding Gums ___

Toothache ___ Oral Lesions ___ Dentures ___

CARDIOVASCULAR:

Chest Pain ___ Angina ___ Palpitations ___ Orthopnea ___ Murmur ___ Claudication ___

RESPIRATORY:

Cough ___ Sputum ___ Hemoptysis ___ Wheeze ___ Frequent Upper Respiratory Infections ___

Dyspnea ___Asthma ___

GASTROENTEROLOGY:

Heart Burn ___ Nausea ___ Vomiting ___ Diarrhea ___ Food Intolerance ___ Laxative use ___

Gas/Indigestion ___ Ulcers ___ Bloating ___ Constipation ___ BM Changes ___ Melena ___ Juandice ___

Hernia ___ Rectal Bleeding/Pain ___ Polyps ___ Colitis ___ Diverticulosis ___

GENITAL/URINARY:

Dysuria___ Frequent Nocturia ___ Retention ___ Urgency ___ Polyuria ___ Dribbling ___ Hematuria ___

Discharge ___ Infections ___

Male: Lesion ___ History of VD __ Testicular Pain ___ Mass ___ Infertility ___ Impotency ___

Female: Menses Onset ___ Menopausal ___ Abnormal Bleeding ___ History of VD ___

MUSC/SKELETAL:

Joint Pain ___ Varicose Veins ___ Claudication ___ Back Pain ___ Edema ___ Stiffness ___ Deformity ___

ENDOCRINE:

Hot flashes ___ Hair Loss ___ Temperature Intolerance ___ Polydipsia ___ Goiter ___

SKIN:

Itch ___ Rash ___ Lesions ___ Color Changes ___ Dermatitis ___ Eczema ___ Breast Lump ___ Pain ___

HEMA/LYMPH:

Easy Bruising ___ Bleeding ___ Anemia ___ Swollen/Painful Lymph Nodes ___

ALLERGY/IMMUNOLOGY:

HIV/AIDS ___ Chronic Steroids ___ Recurrent Infections ___ Allergies ___ Hives ___

NEUROLOGIC:

Numbness ___ Tingling ___ Tremor ___ Fainting ___ Headaches ___ Muscle Weakness ___ Ataxia ___

Paralysis ___ Dizziness ___ Seizures ___ Memory Loss ___ Unconsciousness ___ Stroke ___

PSYCH:

Anxiety ___ Depression ___ Insomnia ___

Name: ____ Date of Birth: __________________________

Date of Review: ____

Vaccination Information Form

Vaccine	Date Received
Tetanus/Tdap (Within last 10 years)	______________________
Pneumovax 23 (Age 65 and older, unless otherwise discussed)	______________________
Prevnar 13 (Age 65 and older, unless otherwise discussed)	______________________
Shingrix (Shingles Vaccine for age 50 and older)	______________________
Hepatitis A	______________________
Hepatitis B	______________________
Flu Vaccine (seasonal)	______________________

Are you interested in discussing or receiving any of the above vaccines at your visit today?

Yes / No

If yes, which ones?

____

____

____