

SUPERIOR MEDICAL CLINICS LLC  
11531 N. 56<sup>TH</sup> ST  
TEMPLE TERRACE, FL 33617

## PATIENT HISTORY.

Patient Name \_\_\_\_\_

Date \_\_\_\_\_

Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_ Marital Status \_\_\_\_\_

Telephone Numbers/Home ( ) \_\_\_\_\_ Work ( ) \_\_\_\_\_

Home Address \_\_\_\_\_

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### ***General Health Review***

Medical History (such as heart disease, stroke, cancer, arthritis, diabetes, hypertension, as well as psychiatric illnesses, etc.)

Surgical History (**unrelated** to pain; such as appendectomy)

Surgical History (**related** to pain; such as laminectomy)

Allergies (include medication and food allergies)

Intolerances (include side effects from previous medications, such as gastritis, nausea, constipation, etc.)

Current Medications (include vitamins and birth control pills, if applicable)

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Office Imprint

Do you have any of the following? (Circle all that apply)

Headaches, Stomach Pain, Chest Pain, Vision Problems , Nausea, Shortness of Breath,  
Hearing Problems, Vomiting M Urinary Problems, Dizziness, Constipation, Rashes  
Difficulty Swallowing, Diarrhea , Swollen Joints, Chronic Fatigue

### *Domestic Situation*

With whom do you live?

Are there any substance abuse issues in the household? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, please explain

Are you able to take care of yourself? Yes \_\_\_\_\_ No \_\_\_\_\_  
If not, please enter name of caregiver

### *Work History*

Job Years worked , Why did you leave?

### *Legal Matters*

Are you presently involved in a lawsuit? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please explain.

### *Substance Use*

Which of the following drugs or substances, if any, have you used in the past? (Circle all that apply) Next to each drug or substance that you've circled, indicate if you used it occasionally ("O"), frequently ("F"), or continuously ("C").

Alcohol \_\_\_\_\_ Barbiturates \_\_\_\_\_ Cocaine \_\_\_\_\_

Heroin \_\_\_\_\_ Amphetamines \_\_\_\_\_ Marijuana \_\_\_\_\_

Other \_\_\_\_\_ Other \_\_\_\_\_ Other \_\_\_\_\_

(specify)

Are you presently using any of the drugs or substances below? (Circle all that apply)

Next to each drug or substance that you've circled, indicate if you use it occasionally ("O"), frequently ("F"), or continuously ("C").

Alcohol \_\_\_\_\_ Barbiturates \_\_\_\_\_ Cocaine \_\_\_\_\_

Heroin \_\_\_\_\_ Amphetamines \_\_\_\_\_ Marijuana \_\_\_\_\_

Other \_\_\_\_\_ Other \_\_\_\_\_ Other \_\_\_\_\_

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## **PATIENT HISTORY.**

(specify) (specify) (specify)

Do you presently smoke cigarettes or use tobacco in any form? Yes \_\_\_\_\_ No \_\_\_ If not, did you  
ever smoke cigarettes or use tobacco in any form? Yes \_\_\_\_\_ No \_\_\_\_\_  
How many packs do (did) you smoke a day? \_\_\_\_\_ For how many years? \_\_\_\_\_

Physician's Name: \_\_\_\_\_

Date: \_\_\_\_\_