

John S. Bruno, M.D., P.A.

2685 Swamp Cabbage Court ≈ Fort Myers, Florida 33901

(239) 936-2522 ≈ Fax (239) 936-7831

Date: _____

Personal Information

Last Name: _____ First: _____ MI: _____

Former Name: _____

Nick Name: _____ Email: _____

SSN: _____

DOB: _____

Sex: Male Female

Marital Status: Single Married Divorced Widowed Legally Separated

Race: White/Non-Hispanic American Indian/Alaskan Asian Black/Non-Hispanic Multi-racial Hispanic

Religion: _____ Church: _____

Referring Provider: _____

Present Address

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Country: _____

Permanent Address

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Perm Phone: _____ Alt. Number: _____ Country: _____

Employer Address

Employer: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Ext: _____ Fax: _____

Occupation: _____ Country: _____

Emergency Contact

Relationship: _____ Nickname: _____

Last Name: _____ First: _____ MI: _____

Address: _____ Apt#: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Country: _____

Consent to Communicate Test Results and Other Medical Records Information

<input type="checkbox"/> Call Work Number	<input type="checkbox"/> Use Pt ID	<input type="checkbox"/> OK to leave Voicemail	<input type="checkbox"/> Ok to leave message with another person	<input type="checkbox"/> Preferred Method	<input type="checkbox"/> Best time to call
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Responsible Party Employer Address

Employer: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **Ext:** _____ **Fax:** _____

Occupation: _____ **Country:** _____

Signature: _____ **Date:** _____

JOHN S. BRUNO, M.D., P.A.

2685 SWAMP CABBAGE COURT ~ FORT MYERS, FLORIDA 33901
(941) 936-2522 ~ FAX (941) 936-7831

PATIENT HISTORY FORM

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NAME _____ Date
DATE of BIRTH

HEIGHT _____ WEIGHT _____

MEDICATIONS: List all current medications including non-prescription drugs, herbs, and supplements

Name	Strength	How Often	Name	Strength	How Often
1. _____			6. _____		
2. _____			7. _____		
3. _____			8. _____		
4. _____			9. _____		
5. _____			10. _____		

ALLERGIES (Please list) _____

PATIENT PAST MEDICAL HISTORY:

	YES	NO		YES	NO		YES	NO		YES	NO
Alcohol/Drug Problem	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Stomach/Intestinal Problems	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Mental Problems	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Asthma/Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Hereditary Diseases	<input type="checkbox"/>	<input type="checkbox"/>	Migraine	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	other	<input type="checkbox"/>	<input type="checkbox"/>

ADDITIONAL MEDICAL PROBLEMS/PREVIOUS HOSPITALIZATIONS/SURGERIES/SERIOUS INJURIES:

- | | |
|----------------------|----------------------|
| 1. _____ Date: _____ | 4. _____ Date: _____ |
| 2. _____ Date: _____ | 5. _____ Date: _____ |
| 3. _____ Date: _____ | 6. _____ Date: _____ |

SOCIAL HISTORY:

Do you currently smoke: No Yes (if yes, packs/day) _____ # Years: _____

Do you drink alcohol: No Yes (if yes, amount/week) _____

Did you smoke in the past? No Yes (when stopped) _____

Do you drink coffee/tea/cola: No Yes (if yes, list amount) _____

FAMILY MEDICAL HISTORY (refer to Patient Past Medical History for diseases):

	Age	Name	Diseases	If Deceased, Cause of Death
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Siblings	_____	_____	_____	_____
Children	_____	_____	_____	_____

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NAME _____

DATE of BIRTH _____

<u>CARDIOVASCULAR</u>	YES	NO	<u>PSYCHIATRIC</u>	YES	NO
Low exercise tolerance			Nervousness or anxiety		
Chest Pain or angina pectoris			Sleep poorly		
Rapid heart beat/skipped beats			Often depressed		
Shortness of breath with activity or lying flat			Change in moods		
Swelling of feet, ankles or hands			Lifestyle change (divorce, death, loss of job)		
<u>RESPIRATORY</u>			Considered/attempted suicide		
Chronic or frequent coughs			<u>ENDOCRINE</u>		
Coughing up blood			Night sweats		
Wheezing			Excessive thirst or urination		
<u>INTEGUMENTARY</u>			Skin becoming drier		
Rash or itching			<u>HEMATOLOGICAL/LYMPHATIC</u>		
Change in moles			Slow to heal after cuts		
Change in hair or nails			Bleed or bruise easy		
Varicose veins			Past transfusion		
Breast pain/lump/discharge			Enlarged glands		
<u>NEUROLOGICAL</u>					
Frequent or recurring headaches					
Lightheaded or dizzy					
Convulsions or seizures					
Tremors					
Speech Problems					
Balance problems					
Memory loss or confusion					
Numbness or tingling sensations					