Gulf Coast Regional Medical Care
16181 Panama City Beach Parkway
Panama City Beach, Florida 32413
Phone: 850-249-1000 | Fax: 850-249-1009

Medical History: Please mark next to any medical conditions or symptoms that you now have or conditions you have had in the past (use the space provided for details: how long, etc.).

HEENT/Pulmonary

☐ No ☐ Yes Glasses/Contacts: _____
☐ No ☐ Yes Vision Changes: _____
☐ No ☐ Yes Glaucoma or Cataracts: _____
☐ No ☐ Yes Cough: _____
☐ No ☐ Yes Coughing up Blood: _____
☐ No ☐ Yes Persistent Hoarseness: _____
☐ No ☐ Yes Shortness of Breath: _____
☐ No ☐ Yes Asthma: _____
☐ No ☐ Yes Tuberculosis: _____
☐ No ☐ Yes COPD/Lung Disease: _____
☐ No ☐ Yes Trouble Swallowing: _____

Cardiac

☐ No ☐ Yes Chest Pain: _____
☐ No ☐ Yes Leg Swelling: _____
☐ No ☐ Yes Palpitations: _____
☐ No ☐ Yes Heart Murmur: _____
☐ No ☐ Yes Irregular Heart Rhythm: _____
☐ No ☐ Yes High Blood Pressure: _____
☐ No ☐ Yes High Cholesterol: _____
☐ No ☐ Yes Heart Disease: _____
☐ No ☐ Yes Heart Attack: _____

Neurological (if yes, please explain)

☐ No ☐ Yes Dizziness: _____
☐ No ☐ Yes Memory Changes: _____
☐ No ☐ Yes Seizures: _____
☐ No ☐ Yes Confusion: _____
☐ No ☐ Yes Chronic Headaches or Migraines (if yes, frequency): _____
☐ No ☐ Yes Stroke: _____

Endocrine/Rheumatology

☐ No ☐ Yes Diabetes/Sugar: _____

If yes, controlled with: ☐ Diet ☐ Insulin ☐ Oral Medications

☐ No ☐ Yes Thyroid Disease/Disorder: _____

☐ No ☐ Yes Heat or Cold Tolerance: _____

☐ No ☐ Yes Low Testosterone: _____

☐ No ☐ Yes Osteoporosis/Osteopenia: _____

☐ No ☐ Yes Joint Pain/Swelling/Arthritis: _____

☐ No ☐ Yes Gout: _____

☐ No ☐ Yes Back Pain: _____

☐ No ☐ Yes Hormone Replacement Therapy: _____

Gastroenterology

☐ No ☐ Yes GERD/Acid Reflux: _____

☐ No ☐ Yes Abdominal Pain or Ulcers: _____

☐ No ☐ Yes Blood in Stool: _____

☐ No ☐ Yes Frequent Diarrhea: _____

☐ No ☐ Yes Frequent Constipation: _____

☐ No ☐ Yes Frequent Vomiting: _____

☐ No ☐ Yes Abnormal Appetite: _____

☐ No ☐ Yes Liver Disease/Hepatitis: _____

☐ No ☐ Yes Change in Appetite: _____

☐ No ☐ Yes Weight Loss or Gain: _____

Urology/Nephrology

☐ No ☐ Yes Urinary Frequency: ☐ Hesitancy ☐ Urgency ☐ Incontinence (Check those that apply)

☐ No ☐ Yes Blood in Urine: _____

☐ No ☐ Yes Weak Urinary System: _____

☐ No ☐ Yes Kidney Stones or Kidney Dysfunction: _____

☐ No ☐ Yes Urinary Tract Infections: _____

☐ No ☐ Yes Kidney Infections: _____

☐ No ☐ Yes BPH (enlarged prostate): _____

☐ No ☐ Yes Trouble Urinating: _____

☐ No ☐ Yes Chronic Renal Insufficiency: _____

☐ No ☐ Yes Dialysis: _____

Psychiatric

☐ No ☐ Yes Anxiety: _____

☐ No ☐ Yes Depression: _____

☐ No ☐ Yes ADD/ADHD: _____

☐ No ☐ Yes Mental Illness: _____

Other

☐ No ☐ Yes Fever: _____

☐ No ☐ Yes Anemia: _____

☐ No ☐ Yes Bleeding Disorder (if yes, please explain): _____

☐ No ☐ Yes Measles: _____

☐ No ☐ Yes Mumps: _____

☐ No ☐ Yes German Measles: _____

☐ No ☐ Yes Scarlet Fever: _____

☐ No ☐ Yes Chicken Pox: _____

☐ No ☐ Yes Polio: _____

☐ No ☐ Yes Meningitis: _____

☐ No ☐ Yes HIV or AIDS: _____

☐ No ☐ Yes Syphilis: _____

☐ No ☐ Yes Lyme Disease: _____

☐ No ☐ Yes Rash: _____

☐ No ☐ Yes Blood Clots: _____

☐ No ☐ Yes Cancer (if yes, please explain): _____

☐ No ☐ Yes Could You be Pregnant: _____

Prevention Health Maintenance

Screening	Date	Result
Pap		
Mammogram		
DEXA Scan/Bone Density Scan		
Colonoscopy		
PSA		
Digital Rectal Exam		
Labs		
Diabetic Eye Exam (if applicable		
EKG (for blood pressure, Diabetes or Coronary Artery Disease)		
Monthly Self Breast or Testicular Exam		
Tetanus Vaccine		
Pneumonia Vaccine: ☐ Prevnar or ☐ Pneumovax (check one)		
Shingles Vaccine		
Flu Vaccine		
Hemoccult: test for blood in stool		

Family History: Check the box and indicate which family member and if alive or deceased)

	Grandparents M – Maternal P – Paternal	**Parents** Mother Father	**Siblings**
DVT/Blood Clot			
Mental Illness			
Kidney Disease			
Heart Disease			
Stroke			
Autoimmune Disease			
Diabetes			
High Cholesterol			
High Blood Pressure			
Epilepsy			
Migraine			
Tuberculosis			
Colon Cancer			
Breast Cancer			
Lung Cancer			
Heart Attack			
Cancer: what type			
Asthma			

Surgical History: Please list any surgeries you have had and the approximate date of that surgery

Surgery	**Date**	**Physician**	**Facility**