Baptist Primary Care – Neptune Beach
700 3rd Street, Suite 102
Neptune Beach, FL 32266
Phone: (904) 246-7520
Fax: (904) 246-7527

Primary Care Physician: Matthew Modansky, MD ☐

Patient name: _____ Today's date: _____

Date of birth: _____ Age: _____ Sex: Male ☐ Female ☐

Home phone: _____ Cell: _____ Work: _____

Emergency contact: _____ Phone: _____ Relationship: _____

Preferred pharmacy name / phone number: _____

Mail order pharmacy name: _____

Main purpose of your visit today: _____

PAST MEDICAL HISTORY: (Check conditions and illnesses for which you have been treated and include year of onset. List any other conditions which may not be included below)

☐ No Known Medical Problems

☐ Allergies _____
☐ Asthma/COPD _____
☐ Atrial fibrillation _____
☐ Anxiety _____
☐ Depression _____
☐ Diabetes _____
☐ Cancer (specify type) _____

☐ Gastric reflux _____
☐ Heart disease _____
☐ High cholesterol _____
☐ Hypertension _____
☐ Thyroid disorder _____
☐ TIA/Stroke _____

OTHER
1) _____
2) _____
3) _____
4) _____
5) _____
6) _____
7) _____
8) _____

PAST SURGICAL HISTORY: (Indicate year)

☐ No Prior Surgeries

☐ Appendectomy _____
☐ Bladder surgery _____
☐ Breast surgery _____
☐ Cesarean section _____
☐ Colon resection _____
☐ Gallbladder _____

☐ Hemorrhoid surgery _____
☐ Hernia repair/type _____
(inguinal, femoral, umbilical, hiatal)
☐ Hysterectomy/reason _____
(i.e. fibroids, endometriosis, pain, cancer)
☐ Other: _____

☐ Tonsillectomy _____
☐ Tonsils/Adenoids _____
☐ Transfusion _____
☐ Tubal ligation _____
☐ Vasectomy _____

Other hospitalizations: _____

OBSTETRIC/GYNECOLOGIC HISTORY:

Number of pregnancies _____ Vaginal deliveries _____ Miscarriages _____ Abortions _____

Number of c-sections _____ Last menstrual period _____

Any pregnancy complications (i.e. gestational diabetes, pre-eclampsia) _____

History of sexually transmitted infections? Yes ☐ No ☐ Type/year _____

FAMILY HISTORY: (Include history of diabetes, heart disease, hypertension, colon, breast, ovarian cancer, other cancers, autoimmune diseases, and age at diagnosis if known)

Relative	Alive/Deceased	Age	Health Problems
Father			
Mother			
Sister			
Brother			
Child			

(Please complete reverse side)

SOCIAL HISTORY:

Marital status: Single ☐ Married ☐ Partner ☐ Widowed ☐ Separated ☐

Children: Yes ☐ No ☐ Ages: _____

Alcohol use: Yes ☐ No ☐ Number of drinks/frequency: _____

Tobacco use: Never ☐ Currently smoke ☐ _____ pack(s) per day for _____ years

Previously smoked ☐ _____ pack(s) per day for _____ years, Quit _____

Chewing tobacco ☐ for _____ years, Quit _____

Caffeine use: None ☐ 1-3 servings/day ☐ 4-6/day ☐ >6/day ☐ Type: _____

Drug use: None ☐ Marijuana ☐ Cocaine ☐ Heroin ☐ Other: _____

Exercise: None ☐ Days per week _____ Type of exercise: _____

Occupation: _____

Ethnic origin: _____

ALLERGIES: ☐ No Known Drug Allergies ☐ No Known Food/Environmental Allergies

Medication/food/environmental allergy Reaction

_____

_____

_____

CURRENT MEDICATIONS: (Include vitamins, supplements, birth control pills, aspirin, eye drops, etc.)

☐ No Current Medications

Medication Name	Dose	Frequency	Refill Needed?
			Yes ☐ No ☐
			Yes ☐ No ☐
			Yes ☐ No ☐
			Yes ☐ No ☐
			Yes ☐ No ☐
			Yes ☐ No ☐
			Yes ☐ No ☐
			Yes ☐ No ☐
			Yes ☐ No ☐
			Yes ☐ No ☐

PREVENTATIVE SCREENINGS:

Last pap smear: _____ History of abnormal pap? Yes ☐ No ☐ When? _____

PCP to perform future paps? Yes ☐ No ☐

Last mammogram: _____ History of abnormal mammogram? Yes ☐ No ☐

Last bone density: _____ Findings: Normal ☐ Osteopenia ☐ Osteoporosis ☐ Unsure ☐

Last PSA/Prostate exam: _____ History of abnormal prostate exam? Yes ☐ No ☐

Vaccinations: (Year) Pneumonia _____ Shingles (Zostavax) _____ Tetanus _____

PREVIOUS PROVIDERS: (Past 5 years)

Name of Provider	Specialty	City/State	Problem seen for	Still Seeing?
				Yes ☐ No ☐
				Yes ☐ No ☐
				Yes ☐ No ☐