ORLANDO
IMMUNOLOGY
CENTER

1707 N. Mills Avenue Orlando, Florida 32803
Phone (407) 647-3960 • Fax (407) 367-0856

Medical History

Name:_________________________ DOB:______________________Date:___________________

Primary Care Physician: ____________________ Reason for your visit: ___________________

Are you allergic to any medication? Yes No

Name of drug Type of reaction

________________ ________________

________________ ________________

Any recent vaccines or immunizations?
What type of vaccine? When was it given?

_________________ ________________

_________________ ________________

What medications are you currently taking?

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Local Pharmacy Name: _____________________ Phone: __________________
Mail Pharmacy Name: ______________________ Phone: __________________

Please check all that apply:

Do you smoke? Never Previous Current **Drink alcohol?** None Rare Weekly Daily
Marijuana? Yes No **Illicit Drugs?** Yes No

Family History: Indicate all medical conditions experienced by family members such as diabetes, hypertension, store, heart disease, cancer, seizure, alcoholism, thyroid, etc.

Relative:

Father:____
Mother: ____
Brother: ____
Sister: ____
Other: ____

Adopted Unknown Family History No Family History

YOUR PAST CONDITIONS			YOUR CURRENT CONDITIONS OR SYMPTOMS		
Anemia or low platelets	Yes	No	Abdominal pain	Yes	No
Cancer	Yes	No	Bruise easily or bleeding	Yes	No
Chicken pox or Shingles	Yes	No	Constipation or diarrhea	Yes	No
Chronic Allergies	Yes	No	Decreased appetite	Yes	No
Chronic Bronchitis or Sinusitis	Yes	No	Depression or Anxiety	Yes	No
Depression or Anxiety	Yes	No	Diffuse body aches	Yes	No
Diabetes	Yes	No	Difficulty swallowing	Yes	No
Heart Disease	Yes	No	Dizziness, Vertigo	Yes	No
Hepatitis or Liver Disease	Yes	No	Earache or discharge	Yes	No
Herpes or Syphilis	Yes	No	Enlarged lymph node	Yes	No
High Blood Pressure	Yes	No	Inability to sleep	Yes	No
Kidney or urinary problems	Yes	No	Lack of energy	Yes	No
Lung or Respiratory Disease	Yes	No	Nausea or vomiting	Yes	No
Muscular, Bone or Joint Disease	Yes	No	Nights sweats	Yes	No
+PPD or Tuberculosis	Yes	No	Sinus Congestion	Yes	No
Psychiatric	Yes	No	Skin pain, numbness, or tightening	Yes	No
Seizures	Yes	No	Skin rash or hives	Yes	No
Sexually Transmitted Diseases	Yes	No	Sore Throat	Yes	No
Skin Disorders	Yes	No	Unusual headaches	Yes	No
Substance Abuse	Yes	No	Urinary problems	Yes	No
Thyroid Problems	Yes	No	Weight loss or gain	Yes	No

Surgeries: ___________________________________ Other: ____________________________

Other: ______________________________________ Other: ____________________________