Brain Fitness Centers
OF FLORIDA

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Name: _____ Date:_____

Address: _____ DOB:_____ Age: _____

City:_____ State: _____ Social Security#: _____

Zip Code:_____ Telephone #: _____ Cell #: _____

Occupation: _____ Work Telephone #: _____

Spouse's Name: _____ E-Mail: _____

Physician's Name: _____ Date of last visit: _____ Referred by:_____

PRESENT MEDICATIONS: Including vitamins, tonics, over the counter medications, pain and sleeping pills, antacids, birth control pills, aspirin, Tylenol, cold remedies and laxatives.

_____ _____ _____

_____ _____ _____

PAST MEDICAL HISTORY – Do you have, or have you had any of the following?

	DATE		DATE
High Blood Pressure	_____	Tuberculosis	_____
Heart Trouble	_____	Positive TB test	_____
Heart Attack	_____	Diabetes	_____
Rheumatic Fever	_____	Thyroid Problems	_____
Anemia	_____	Arthritis	_____
Stroke	_____	Hepatitis	_____
Cancer	_____	Gallbladder trouble	_____
Venereal Disease	_____	Bladder Infections	_____
Colitis	_____	Other	_____
Peptic Ulcer	_____	**Women:**	
Hiatal Hernia	_____	Age started menstruation:	_____
Epilepsy	_____	Last menstrual period:	_____
Head Injury	_____	Number of pregnancies:	_____
Chronic Bronchitis	_____	Cesarean Sections:	_____
Emphysema	_____	Number of miscarriages:	_____
Asthma	_____	Abortions:	_____

PAST SURGICAL HISTORY

	DATE		DATE
Eyes	_____	Prostate	_____
Ears	_____	Womb (Uterus)	_____
Nose	_____	Hysterectomy	_____
Throat	_____	Ovary	_____
Thyroid	_____	Appendectomy	_____
Tonsils	_____	Chest	_____
Skin	_____	Heart	_____
Hip	_____	Spine	_____
Breast	_____	Varicose Veins	_____
Gallbladder	_____	Kidney	_____
Hernia	_____	Bladder repair	_____
Hemorrhoids	_____	Exploratory	_____
Stomach	_____	Plastic Surgery	_____
Colon	_____	Fractures	_____
Rectum	_____		

Any other operations:

_____

_____

HEALTH MAINTENANCE

	DATE		DATE
Last pap smear	_____	Colonoscopy	_____
Last TB skin test	_____	Last Pneumonia Vaccine	_____
Last tetanus booster	_____	Last Flu Vaccine	_____
Last mammogram	_____	Shingles Vaccine	_____
Stool Cards	_____		

Please list any medication, food, dust and/or pollen that you are allergic to: _____

_____

What type and quantity of exercise and/or activity do you get regularly? _____

_____

SOCIAL HISTORY

Home State: _____

Marital Status: **Single** **Married** **Widowed** **Separated** **Divorced**

Have you ever smoked? **YES** **NO** How many years? _____

Do you drink alcoholic beverages? **YES** **NO**

How much per day or week now? _____ Per Day _____ Per Week

Career/Previous Career: _____

Highest Level of Education Achieved _____

Diet Restrictions _____

Occupational Exposure _____

Any International Travel within the last 3 years _____

FAMILY HISTORY

	AGE	**ALIVE**	**AGE AT DEATH**	**BASIC MEDICAL PROBLEMS**
Mother	_____	_____	_____	_____
Father	_____	_____	_____	_____
Brothers	_____	_____	_____	_____
Sisters	_____	_____	_____	_____
Children	_____	_____	_____	_____

Do any of the following run in the family?

	YES	**WHO**		**YES**	**WHO**
High Blood Pressure	_____	_____	Tuberculosis	_____	_____
Heart Trouble	_____	_____	Kidney Disease	_____	_____
Strokes	_____	_____	Epilepsy	_____	_____
Emphysema	_____	_____	Bleeding Disorder	_____	_____
Diabetes	_____	_____	Cancer	_____	_____
Thyroid/Goiter	_____	_____			