John B. DeCosmo, DO, PA
(727) 498-6488 Fax: (727) 362-6772

Name_____ Date of Birth_____
Address/City/State/Zip_____
Email_____ Mobile Phone_____
Home Phone_____ Emergency Contact_____
Primary Care Physician Name/Address/Phone/Fax_____
_____
Who Referred You to This Office? _____
What Are Your Symptoms? _____
_____

Medical History: (Circle all that apply.)
A-Fib/Flutter Anemia Asthma Blood Clotting Problems Cancer (type)_____
Stroke (CVA) Cirrhosis Hepatitis COPD Heart Attack
Diabetes Endocarditis Gastritis Ulcers Heart Valve Disorder
High Blood Pressure High Cholesterol Hypothyroid Hyperthyroid Disease
Osteoarthritis Overweight Peripheral Arterial Disease Kidney Disease
Rheumatic Fever Seizures Varicose Veins
Other _____

Surgeries: List Surgeries and year performed please.
_____
_____
_____

Smoking Status: (circle all that apply) Chewing Tobacco Cigars Never Smoker
Cigarettes (How many packs per day? _____ for how many years?_____) Year quit?_____
Alcohol: How many drinks per week? _____
Recreational Drugs:_____

Family History:
Circle all that apply and note which family member with the following abbreviations; M for mother, F for father, B for brother, S for sister, MGF for maternal grandfather, MGM for maternal grandmother, PGF for paternal grandfather and PGM for paternal grandmother.

Abnormal Heart Rhythm _____
Alcohol / Drug Abuse _____
Anemia _____
Arthritis _____
Asthma _____

Cancer _____
Diabetes _____
Gastritis / Ulcer _____
Heart Attack _____
Heart Disease _____
Heart Failure _____
High Blood Pressure _____
High Cholesterol _____
Kidney Problems _____
Liver Problems _____
Stroke _____
Thyroid Problems _____
Other_____
_____
No Family Medical History

Medication Allergies:
_____
Current Medications with Strength and Dose; _____
_____
_____
_____

Review of Systems: (Circle all of the symptoms that apply please.)
Constitutional;
Fever Unusual fatigue or weakness Chills
Sleep with more than one pillow Weight loss Weight gain
Reviewed and Negative

HEENT;
Blurred vision Double vision Change in vision Difficulty swallowing
Nose bleeds Mouth sores Bleeding gums Earache Eye discharge/ drainage
Eye Pain Headache Postnasal drip Sore throat Swollen glands
Reviewed and Negative

Cardiovascular;
Chest Pain Shortness of breath with lying down Cough Palpitations
Shortness of breath with exertion Shortness of breath without exertion
Swelling in Ankles/ Feet Varicose veins Wheezing
Reviewed and Negative

Respiratory;
Cough Wheeze Cough up blood Short of breathe Pain with breathing
Snore Gasp when sleeping
Reviewed and negative

Integumentary (Skin);
Itchiness Rash Wound/Ulcer Unusual moles or dark spots
Reviewed and Negative

Hematologic;
Blood clotting problems Lymphedema (swelling) Unexplained Bruising
Reviewed and Negative

Endocrine;
Cold intolerance Hot Flashes Excessive thirst Excessive Urination
Urinating at night more than once or twice
Reviewed and Negative

Gastrointestinal;
Abdominal pain Constipation Diarrhea Heartburn Nausea
Vomiting Blood in stool Black tarry stools
Reviewed and negative

Genitourinary;
Urinary frequency Urinary difficulty Urinary hesitancy Pain with urination
Night time urination more than once or twice per night Blood in urine
Reviewed and Negative

Immune/Allergy;
Current Cancer Treatment Food intolerance Latex allergy Seasonal allergies
Reviewed and Negative

Musculoskeletal;
Back pain Joint pains Leg/Hip pain when walking Neck pain Leg cramps
Pain at night Muscle weakness
Reviewed and Negative

Neurological;
Recurring headaches Light headed or dizzy Numbness or tingling Tremors
Head injury
Reviewed and negative