Boca Grande HEALTH CLINIC

INFORMATION FOR YOUR PHYSICIAN

PATIENT NAME _____

MEDICATIONS:
List prescription and over-the-counter/supplements/drops/skin products.
Please bring ALL medications to appointment for review.
List medication, dose and how you take.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

MEDICATION ALLERGIES/SIDE EFFECTS:
List substance and reaction type.

_____

_____

List any food allergies.

_____

SURGERIES:
List any prior surgeries or serious injuries in life and approximate date.

_____

_____

_____

_____

_____

Have you had any problems with anesthesia? Yes _____ No _____

PATIENT NAME _____

MEDICAL PROBLEMS/INJURIES/HOSPITALIZATIONS:
Circle any problem in the past requiring a physician visit.

Please include: adrenal; allergies; anemia; anorexia/bulimia; anxiety; arthritis; attention deficit; back or neck problems; cancers; carotid artery blockage; colon, like irritable bowel syndrome, polyps, diverticulitis, colitis; dementia; depression; deep venous thrombosis; diabetes; ear, nose and throat; eye, like cataract, glaucoma, macular degeneration; fibromyalgia; gallbladder; gout; gastroesophageal reflux; gynecologic infertility; heart, like angina, atrial fibrillation, congestive heart failure, coronary artery blockage; irregular heart rhythm, heart attack, heart murmur, valve problem; headaches; high cholesterol; hypertension; infections; insomnia; kidneys, like kidney stones, frequent urinary tract infections; liver; lung, like asthma, emphysema, pneumonia, tuberculosis; lupus; lymph node problems; multiple sclerosis; neuropathy; osteoporosis; ovary; pancreas; Parkinson's disease; pituitary; platelet problems; polio; polymyalgia heumatic; prostate; psoriasis; pulmonary embolism; reflux; rhinitis; seizures; sexual diseases; Sjogren's syndrome; sleep apnea; spleen; stroke/tia; thyroid; ulcers; uterus/cervix; vein problems; white blood cell problems.

List approximate date(s) and treatment(s) received for any conditions circled above. Are you still having problems from this condition?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Any abnormal lab or radiology tests before? Yes _____ No _____

If yes, please explain:

_____
_____

Do you have any implants such as breast; defibrillator; lens; pacemaker; pain pump; stents, etc.?
Please list: _____
_____
_____

PATIENT NAME _____

FAMILY HISTORY:
List age, whether living or deceased, and any known health problems.

Father: _____
Mother: _____
Brothers: _____
_____
Sisters: _____
_____
Half Siblings (blood related): _____
_____

Any significant illness in grandparents, aunts, uncles, cousins, or children?
_____
_____

Any breast, ovarian, colon, prostate cancers in family? _____

Any bleeding or clotting problems in family? _____

SOCIAL HISTORY:
Relationship Status: Single, Married, Divorced, Widow/Widower, Partner (Circle one)
Children: _____ Grandchildren _____
Occupation: _____ Highest Education: _____

Tobacco: (include oral, cigar, pipe)
Number of years smoked? _____ Number of packs per day? _____
Current: _____
Prior _____ Quit date: _____

Alcohol: (include beer, liquor, wine)
Number of drinks per day? _____ How many days per week? _____
Current _____
Past _____
Diet: _____ Exercise: _____ Type _____ How Often _____

Caffeine: (include coffee, cola, tea) List: _____

Substance Abuse: _____ List past or current use _____

Do you have Advanced Directives (ex. Living Will)? Yes _____ No _____

PATIENT NAME _____

PREVENTION:

Date of last physical exam: _____

Female: Last Pap _____ Male: Last PSA _____

Last Mammogram _____

Was either ever abnormal? _____

Have you ever had: (if so, when was most recent)

Stress test _____ Cardiac calcium CT score _____ Carotid Ultrasound _____

Iron levels checked _____ Colonoscopy _____ Aorta ultrasound _____

Bone density for osteoporosis _____ Chest x-ray _____

When was your last:

Dermatology visit _____ Cholesterol checked _____

Hearing test _____ Eye exam _____

IMMUNIZATIONS:

Last tetanus? _____

Have you had a pneumonia vaccine? _____

Have you received a shingles vaccine? _____ Did you have chicken pox as a child?

Yes ____ No ____

Do you get influenza vaccines? _____ Are you allergic to eggs? _____

Ever have a positive PPD (TB skin test)? _____

Ever have Hepatitis A or B vaccines? _____

Ever have illness traveling outside the U.S.? _____

REVIEW OF SYSTEMS:

Please **circle** if you currently have any of the following symptom(s).

General: Chills; Daytime sleepiness; Fatigue; Fever; Night sweats; Weight gain or Weight loss.

Eyes: Blurred vision, Double vision; Dry eyes; Eye drainage; Eye pain; Glasses/contacts; Light bothers eyes; Vision loss.

Ears: Ear pain; Hearing aids; Hearing loss; Tinnitus; Vertigo/dizziness; Wax problems.

Nose: Drainage; Nasal congestion; Nosebleeds; Sinus infections; Sneezing; Snoring.

Throat: Change in voice; Choking; Dental problems; Dentures; Hoarseness; Sores in throat or on lips; Sore throat; Swallowing problems.

Cardiovascular: Chest pain; Cramps in legs while walking; Fainting/Dizziness; Palpitations/irregular heart beat; Shortness of breath while asleep; Swelling in legs; Tightness or heaviness in chest; Varicose veins.

Respiratory: Cough; Cough up blood; Pain with deep breath; Shortness of breath, either at rest or with activity; Wheezing.

Gastrointestinal: Abdominal pain; Acid taste in mouth; Black stools; Bloating; Blood in stool; Change in appetite; Change in bowels; Constipation; Diarrhea; Heartburn; Hemorrhoids; Jaundice; Nausea; Vomiting.

Genitourinary: Change in testicles; Genital sores or growths; Menstrual cycle problems; Protein or blood in urine; Sexual problems; Urine burning, frequency, leakage or slow flow; Vaginal discharge; Wake up during sleep to urinate;

Musculoskeletal: Back or neck problems; Bursae, muscle or tendon problems; Joint pain, stiffness or swelling.

Skin: Acne; Changes in hair or nails; Dryness; Itching; Lumps; Moles changing; Rashes.

Neurological: Balance problems; Funny sensations; Headaches; Lightheadedness; Memory Loss; Numbness; Paralysis; Shaking; Tremor; Weakness.

Hematology: Body piercings; Bruising; Excess bleeding; Lymph node enlargement; Prior transfusions; Tattoos.

Endocrinology: Change in ring or hat size; Change in sexual desire; Change in skin pigment; Excessive sweating; Increased thirst; Steroids/cortisone use; Stretch marks; Unusual hair growth or hair loss; Unusually hot or cold;

Allergy/Immune System: Allergies, seasonal or year-round; HIV risk factors; Hives; Prior allergy shots; Recurrent infections.

Breast: Mass; Nipple discharge; Skin changes; Tenderness.

Psychological: Abuse (sexual or verbal); Crying spells; Loss of interest in pleasurable activities; Nervousness; Obsessive/compulsive behaviors; Personality change; Poor concentration; Sadness; Sleep disturbance; Stress; Suicidal thoughts.