Trinity Family Physicians

Let Our Family Care for Yours

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1817 Cypress Brook Drive, Suite 101

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Phone (727) 834 – 8377 fax (727) 834 – 8371

Clinical Summary

Welcome to our practice. Please answer all the questions found below to the best of your ability.

Name: ________________________________ **Date:** ______________________

Reason for today's visit: ____

Allergies to any medications: ____

Previous Hospitalizations/Surgeries/Procedures:	When:	Doctor:
________________________________	______	__________
________________________________	______	__________
________________________________	______	__________
________________________________	______	__________

Have you had a colonoscopy: YES or NO If so, when: ________ Doctor____________

FOR WOMEN ONLY

1. Last Pap Smear: _________ Do you have a GYN: ______ If so, who__________
2. Are your periods normal: _______
3. Last menstrual period: __________
4. Number of pregnancies:____________ vaginal deliveries: _________C-Sections: ____________
5. Last Mammogram: _________________
6. Last Bone Density Screening: ________________

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Medication List

Please list your current medications:

Name	Strength	Cap/Tab/Other?	Frequency
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			

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PATIENT HISTORY SHEET

PAST MEDICAL HISTORY:

☐ ABDOMINAL AORTIC ANEURYSM
☐ ATTENTION DEFICIT DISORDER
☐ ALLERGIC RHINITIS
☐ ANXIETY
☐ ATRIAL FIBRILLATION
☐ BLOOD TRANSFUSION
☐ BREAST LUMP
☐ CANCER: BLADDER
☐ CANCER: BREAST
☐ CANCER: LEUKEMIA
☐ CANCER: LYMPHOMA
☐ CANCER: MOUTH
☐ CANCER: PROSTATE (male)
☐ CANCER: SKIN
☐ CANCER: THYROID
☐ CARDIOMYOPATHY
☐ CATARACTS
☐ CHRONIC BLADDER INFECTIONS
☐ CHRONIC PANCREATITIS
☐ COLOSTOMY
☐ COPD (Chronic obstructive pulmonary disease)
☐ CONSTIPATION
☐ DIABETES
☐ DIVERTICULOSIS
☐ DVT (DEEP VENOUS THROMBOSIS)
☐ EMPHYSEMA
☐ ABNORMAL PAP SMEAR (female)
☐ ADOPTED
☐ ANEMIA
☐ ASTHMA
☐ BACK PAIN
☐ BENIGN PROSTATIC HYPERTROPHY
☐ BRONCHITIS
☐ CANCER: BONE
☐ CANCER: COLON
☐ CANCER: LUNG
☐ CANCER: MELANOMA
☐ CANCER: OVARIAN (female)
☐ CANCER: RENAL CELL
☐ CANCER: TESTICULAR (male)
☐ CANCER: UTERINE (female)
☐ CARPAL TUNNEL
☐ CVA (STROKE)
☐ CHRONIC DIARRHEA
☐ CIRRHOSIS
☐ CONGESTIVE HEART FAILURE (CHF)
☐ CORONARY ARTERY DISEASE
☐ DEPRESSION
☐ DIVERTICULITIS
☐ DNR (DO NOT RESUSCITATE)
☐ EDEMA
☐ GALLBLADDER DISEASE

Name:

☐ GERD	☐ GOUT
☐ HEAD OR NECK RADIATION	☐ HEADACHE
☐ HEART DISEASE	☐ HEART MURMUR
☐ HYPERTENSION (High blood pressure)	☐ HERNIA
☐ HYPOTHYROIDISM	☐ HYPERLIPIDEMIA (High cholesterol)
☐ INSOMNIA	☐ MACULAR DEGENERATION
☐ MIGRAINE HEADACHE	☐ MITRAL VALVE PROLAPSE
☐ OSTEOPENIA	☐ OSTEOPOROSIS
☐ PALPITATIONS	☐ PNEUMONIA
☐ POLIO	☐ PULMONARY NODULE
☐ PULMONARY EMBOLUS	☐ RHEUMATIC FEVER
☐ RHEUMATOID ARTHRITIS	☐ SEIZURES
☐ THYROID NODULE	☐ TIA (Transient ischemic attack aka mini-stroke)
☐ ULCERS	☐ URINARY INCONTINENCE
☐ UTERINE PROLAPSE (female)	☐ VERICOSE VEINS

☐ OTHER: ____

____

SOCIAL HISTORY:

DO YOU SMOKE? ☐ YES ☐ NO

IF YES, PACKS PER DAY: ☐ ONE ☐ TWO ☐ THREE ☐ FOUR ☐ FIVE+

DO YOU DRINK ALCOHOL? ☐ YES ☐ NO

IF YES, DRINKS PER DAY: ☐ ONE OR LESS ☐ TWO ☐ THREE ☐ FOUR ☐ FIVE+

DO YOU USE RECREATIONAL DRUGS? ☐ YES ☐ NO

DO YOU EXERCISE REGULARLY? ☐ YES ☐ NO

DO YOU USE CAFFEINE? ☐ YES ☐ NO

IF YES, DRINKS PER DAY: ☐ ONE OR LESS ☐ TWO ☐ THREE ☐ FOUR ☐ FIVE+

MARITAL STATUS:

☐ MARRIED ☐ SINGLE ☐ WIDOWED ☐ DIVORCED

Name:

FAMILY HISTORY:

MOTHER: ☐ ALIVE ☐ DECEASED

☐ AAA (ABDOMINAL AORTIC ANEURYSM)
☐ CHF (CONGESTIVE HEART FAILURE)
☐ DEPRESSION
☐ DIABETES
☐ HEART DISEASE
☐ HYPERLIPIDEMIA (High cholesterol)
☐ CANCER
☐ COPD (Chronic obstructive pulmonary disease)
☐ DVT (DEEP VENOUS THROMBOSIS)
☐ GALLBLADDER DISEASE
☐ HYPERTENSION
☐ HYPOTHYROIDISM

FATHER: ☐ ALIVE ☐ DECEASED

☐ AAA (ABDOMINAL AORTIC ANEURYSM)
☐ CHF (CONGESTIVE HEART FAILURE)
☐ DEPRESSION
☐ DIABETES
☐ HEART DISEASE
☐ HYPERLIPIDEMIA (High cholesterol)
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☐ GALLBLADDER DISEASE
☐ HYPERTENSION
☐ HYPOTHYROIDISM

SIBLINGS: # BROTHERS ____ # SISTERS _____

☐ AAA (ABDOMINAL AORTIC ANEURYSM)
☐ CHF (CONGESTIVE HEART FAILURE)
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☐ DIABETES
☐ HEART DISEASE
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☐ GALLBLADDER DISEASE
☐ HYPERTENSION
☐ HYPOTHYROIDISM

CHILDREN: # BOYS ____ # GIRLS _____

☐ AAA (ABDOMINAL AORTIC ANEURYSM)
☐ CHF (CONGESTIVE HEART FAILURE)
☐ DEPRESSION
☐ DIABETES
☐ HEART DISEASE
☐ HYPERLIPIDEMIA (High cholesterol)
☐ CANCER
☐ COPD (Chronic obstructive pulmonary disease)
☐ DVT (DEEP VENOUS THROMBOSIS)
☐ GALLBLADDER DISEASE
☐ HYPERTENSION
☐ HYPOTHYROIDISM

Name:

REVIEW OF SYSTEMS:

Which of the following symptoms have you had in the past **2 weeks**?

- ☐ FEVERS OR SWEATS
- ☐ UNDESIRED WEIGHT LOSS
- ☐ VISION WORSENING
- ☐ DOUBLE VISION
- ☐ HEARING LOSS
- ☐ DIFFICULTY SWALLOWING
- ☐ CHEST PAIN
- ☐ CHEST HEAVINESS
- ☐ SHORTNESS OF BREATH
- ☐ COUGHING UP BLOOD
- ☐ BLOOD IN STOOL
- ☐ VOMITING BLOOD
- ☐ BLOOD IN URINE
- ☐ URINARY DISCHARGE
- ☐ JOINT SWELLING
- ☐ MUSCLE WEAKNESS
- ☐ IRRITATED MOLES
- ☐ CHANGING MOLES
- ☐ CONVULSIONS
- ☐ FALLING
- ☐ LACK OF PLEASURE/FUN
- ☐ THOUGHTS OF SUICIDE
- ☐ HOT FLASHES
- ☐ CAN'T TOLERATE HOT/COLD TEMP
- ☐ BRUISING EASILY
- ☐ BLEEDING FREQUENTLY
- ☐ WHEEZING
- ☐ NASAL CONGESTION
- ☐ SEX LIFE COULD BE BETTER
- ☐ SNORING