



Last Name: _____ First Name: _____

Date of Birth: _____ Date of Visit: _____

- I am having severe chest pain and shortness of breath, and I think I may be having a heart attack. Yes No
- I am having numbness/weakness in my arms, legs or face, and I think I may be having a stroke. Yes No
- I have recently lost consciousness or I am having extreme weakness, and I think I may pass out. Yes No
- I am pregnant and I am having vaginal bleeding. Yes No

If you answered yes to any of the above questions or if you have a life-threatening medical concern, please notify staff immediately.

Medications:

None

Please list all medications that the patient is currently taking: _____

Please note: Our physicians will not write for, dispense or refill Schedule II or Schedule III drugs- including narcotics (such as hydrocodone, oxycodone, Percocet, Vicodin), benzodiazepines (such as Xanax, lorazepam), or amphetamines (such as Adderall, phentermine), written by other providers.

Past and Current Medical Conditions:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> None | <input type="checkbox"/> COPD/Emphysema | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Acid Reflux / GERD | <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Peripheral Artery Disease |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Depression | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Prostate Cancer |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Irritable Bowel (IBS) | <input type="checkbox"/> Seizures/Epilepsy |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Enlarged Prostate | <input type="checkbox"/> Joint Injuries | <input type="checkbox"/> STD |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Erectile Dysfunction | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Skin Cancer |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Gallbladder Disease | <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Gastrointestinal Ulcers | <input type="checkbox"/> Lung Cancer | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Vision Problems |
| <input type="checkbox"/> Broken or Fractured Bone(s) | <input type="checkbox"/> Gout | <input type="checkbox"/> Lupus | <input type="checkbox"/> Other / Not Listed |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Migraine | _____ |
| <input type="checkbox"/> Clotting Disorder | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Obesity | _____ |
| <input type="checkbox"/> Colon/Rectal Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Osteoporosis | _____ |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Overactive Bladder | _____ |

Drug Allergies:

- | | | | |
|--|---------------------------------------|---|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Depakote | <input type="checkbox"/> Morphine | <input type="checkbox"/> Other / Not Listed |
| <input type="checkbox"/> Amoxicillin | <input type="checkbox"/> Dilantin | <input type="checkbox"/> Other Antibiotics | _____ |
| <input type="checkbox"/> Anti-Seizure Medicine | <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Other Pain Killers | _____ |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Insulin | <input type="checkbox"/> Penicillin | _____ |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Iodine | <input type="checkbox"/> Sulfa | _____ |
| <input type="checkbox"/> Contrast Dye | <input type="checkbox"/> Latex | | |

Surgeries or Procedures:

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Colon/Bowel Surgery | <input type="checkbox"/> Kidney Surgery | <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> Angioplasty | <input type="checkbox"/> Cosmetic Surgery | <input type="checkbox"/> Mastectomy | <input type="checkbox"/> Tubal Ligation |
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Gallbladder Surgery | <input type="checkbox"/> Neurosurgery | <input type="checkbox"/> Vasectomy |
| <input type="checkbox"/> Back Surgery | <input type="checkbox"/> Gastric Bypass | <input type="checkbox"/> Orthopedic Surgery | <input type="checkbox"/> Other / Not Listed |
| <input type="checkbox"/> Breast Biopsy | <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Pacemaker Implantation | _____ |
| <input type="checkbox"/> Cardiac Stent / Catheterization | <input type="checkbox"/> Hernia Repair | <input type="checkbox"/> Prostate Surgery | _____ |
| <input type="checkbox"/> Cataract Surgery | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Sinus Surgery | _____ |
| <input type="checkbox"/> Cesarean Section | <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Thyroid Surgery | _____ |

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Wesley Chapel | Carrollwood | Westchase | South Tampa | Seminole | St. Petersburg | Riverview

Last Name: _____ First Name: _____

Date of Birth: _____ Date of Visit: _____

Hospitalizations:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Depression | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Other / Not Listed |
| <input type="checkbox"/> Alcoholism or Substance Abuse | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver Disease | _____ |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Pneumonia | _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke | _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Seizures / Epilepsy | _____ |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Injury | <input type="checkbox"/> Thyroid Disease | |

Family Medical History:

	Father	Mother	Grandfather	Grandmother	Siblings	Children
Acid Reflux / GERD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disorder / Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression / Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gastrointestinal Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease / Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures or Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other / Not Listed						

Social History:

- | | | |
|---------------------------|------------------------------|-----------------------------|
| Are you a current smoker? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you drink alcohol? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you drink caffeine? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Review of Systems: Please mark all recent symptoms associated with today's visit.

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Runny Nose | <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Loss of Consciousness |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Nose Bleeds | <input type="checkbox"/> Nausea | <input type="checkbox"/> Weakness or Paralysis |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Sore Throat | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Tingling or Numbness |
| <input type="checkbox"/> Weight Loss (unintentional) | <input type="checkbox"/> Loss of Voice | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Weight Gain (unintentional) | <input type="checkbox"/> Postnasal Drip | <input type="checkbox"/> Constipation | <input type="checkbox"/> Easy Bruising |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Throat Swelling | <input type="checkbox"/> Dark Tarry Stools | <input type="checkbox"/> Easy Bleeding |
| <input type="checkbox"/> Loss of Vision | <input type="checkbox"/> Dental Pain | <input type="checkbox"/> Blood in Stools | <input type="checkbox"/> Leg Cramps |
| <input type="checkbox"/> Blurring of Vision | <input type="checkbox"/> Neck Stiffness | <input type="checkbox"/> Pain with Urination | <input type="checkbox"/> Heat or Cold Intolerances |
| <input type="checkbox"/> Eye Pain | <input type="checkbox"/> Swollen Neck Glands | <input type="checkbox"/> Frequent Urinations | <input type="checkbox"/> Increased Thirst |
| <input type="checkbox"/> Eye Irritation or redness | <input type="checkbox"/> Chest Pain (Cardiac) | <input type="checkbox"/> Strong Urge to Urinate | <input type="checkbox"/> Rash |
| <input type="checkbox"/> Itchy Eyes | <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Difficulty Urinating | <input type="checkbox"/> Itchy Skin |
| <input type="checkbox"/> Drainage from Eyes | <input type="checkbox"/> Leg Swelling | <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Dry Skin |
| <input type="checkbox"/> Earache | <input type="checkbox"/> Cough | <input type="checkbox"/> Urine Output Changes | <input type="checkbox"/> Lumps or Swelling |
| <input type="checkbox"/> Decreased Hearing | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Changes in Hair or Nails |
| <input type="checkbox"/> Ringing of Ears | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Joint Swelling | <input type="checkbox"/> Depressed Mood |
| <input type="checkbox"/> Ear Discharge | <input type="checkbox"/> Coughing up Blood | <input type="checkbox"/> Muscle Aches | <input type="checkbox"/> Sleep Disturbances |
| <input type="checkbox"/> Sinus Pain or Pressure | <input type="checkbox"/> Loss of Appetite | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Other / Not Listed |
| <input type="checkbox"/> Nasal Congestion | <input type="checkbox"/> Painful Swallowing | <input type="checkbox"/> Back Pain | |

