Florida Medical Clinic
Your life. Our specialty.

Internal Medicine
Zephyrhills

Patient Personal History & Health Assessment

Name: _____ **Date:** _____ **DOB:** _____

Personal History:

Please list all medications you are currently taking.

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

List all medication allergies:

_____ Reaction: _____
_____ Reaction: _____
_____ Reaction: _____
_____ Reaction: _____
_____ Reaction: _____

Past Medical History (Personal):

Have you ever had any of the following illnesses?

	Yes	No		Yes	No
Alcohol Overuse	☐	☐	High Cholesterol	☐	☐
Allergies (not including meds)	☐	☐	Kidney Disease	☐	☐
Anemia	☐	☐	Prostate Problems	☐	☐
Anxiety/Depression	☐	☐	Rheumatic Fever	☐	☐
Arthritis	☐	☐	Seizure Disorder	☐	☐
Asthma	☐	☐	Sexually Transmitted Diseases	☐	☐
Cancer	☐	☐	Shingles	☐	☐
Colitis	☐	☐	Sickle Cell Anemia	☐	☐
COPD	☐	☐	Sleep Apnea	☐	☐
Colon Polyps	☐	☐	Stomach Ulcers	☐	☐
Diabetes	☐	☐	Stroke	☐	☐
Frequent Kidney or Bladder Infections	☐	☐	Thyroid Problems	☐	☐
Frequent Lung infections	☐	☐	Tuberculosis	☐	☐
Gout	☐	☐	Whooping Cough	☐	☐
Hay Fever	☐	☐	Osteoporosis	☐	☐
Heart Attack	☐	☐	Other: _____		
Other Heart Disease	☐	☐			
Hepatitis	☐	☐			
High Blood Pressure	☐	☐			

Florida Medical Clinic
Your life. Our specialty.

Internal Medicine
Zephyrhills

Patient Personal History & Health Assessment

Name: _____ **Date:** _____ **DOB:** _____

Personal Habits:

Have you ever smoked? ☐ Yes ☐ No Are you currently smoking? ☐ Yes ☐ No
If yes, number of cigarettes per day _____

Do you use smokeless tobacco? ☐ Yes ☐ No If yes, how long? _____

Do you drink alcohol? ☐ Yes ☐ No If yes, ☐ Beer ☐ Wine ☐ Liquor
How much do you drink per week? _____

Have you ever used any of the following: ☐ Marijuana, ☐ LSD, ☐ Heroin, ☐ Cocaine
Have you ever used prescription drugs? ☐ Yes ☐ No

Occupation: _____

Operations: *list past surgeries and dates*

_____ _____ _____
_____ _____ _____
_____ _____ _____

Hospitalizations: *list reason for admission & approximate date*

_____ _____ _____
_____ _____ _____
_____ _____ _____

Serious Injuries: *Include fractures, head & back injuries*

_____ _____ _____
_____ _____ _____
_____ _____ _____

Family History:

Father:	Living	_____	Deceased	_____	Cause of Death:	_____
Mother:	Living	_____	Deceased	_____	Cause of Death:	_____
Brothers:	Living	_____	Deceased	_____	Cause of Death:	_____
Sisters:	Living	_____	Deceased	_____	Cause of Death:	_____

Check if any blood relative has or had any of the following illnesses.

	Yes	No	Relative
Arthritis	☐	☐	_____
Asthma	☐	☐	_____
Bleeding Disorders	☐	☐	_____
Cancer	☐	☐	_____
Congenital Heart disease	☐	☐	_____

Florida Medical Clinic
Your life. Our specialty.

Internal Medicine
Zephyrhills

Patient Personal History & Health Assessment

Name: _____ **Date:** _____ **DOB:** _____

Family History: (Continued)

	Yes	No	Relative
Depression	☐	☐	_____
Diabetes	☐	☐	_____
Emphysema	☐	☐	_____
Epilepsy	☐	☐	_____
Heart Attack	☐	☐	_____
High Blood Pressure	☐	☐	_____
Kidney Disease	☐	☐	_____
Leukemia	☐	☐	_____
Migraine	☐	☐	_____
Rheumatic Fever	☐	☐	_____
Sickle Cell Anemia	☐	☐	_____
Stroke	☐	☐	_____
Tuberculosis	☐	☐	_____
Ulcers	☐	☐	_____
Other: _____	☐	☐	_____

Obstetric History:

How many pregnancies have you had? _____
Miscarriages/Abortions? _____
Premature Births? _____
Date of last menstrual period: _____
Age that menopause began: _____
Date of last pap smear: _____ Results: _____
Date of last mammogram: _____ Results: _____

Screenings for Men & Women:

Date of last colonoscopy: _____ Results: _____
Date of last bone density: _____ Results: _____
Date of last rectal examination: Date _____ Results: _____
of last mammography: _____ Results: _____
Date of last complete blood tests: _____ Results: _____
Date of last test for blood in stool: _____ Results: _____
Date of last pelvic and pap test: _____ Results: _____
Date of last chest X-Ray: _____ Results: _____
Date of last PSA: _____ Results: _____

Immunizations:

Hepatitis B _____
Pneumococcal _____
Influenza (Flu) _____
Tetanus _____
Chicken Pox _____
Shingles _____

Florida Medical Clinic
Your life. Our specialty.

Internal Medicine
Zephyrhills

Patient Personal History & Health Assessment

Name: _____ **Date:** _____ **DOB:** _____

Review of Systems:

Please check any problems you currently have.

Eyes: Visual problems ☐ / blurry vision ☐ / red eyes ☐ / itchiness ☐ / pain ☐
Other: _____ N/A ☐

Ears: Hearing loss ☐ / ringing in your ears ☐ / pain ☐ / discharge ☐
Other: _____ N/A ☐

Nose: Nasal allergies ☐ / nose bleeds ☐ / discharge ☐ / sinus problems ☐
Other: _____ N/A ☐

Throat: Swallowing difficulty ☐ / frequent sore throats ☐ / speech problems ☐
Other: _____ N/A ☐

Mouth: Dental problems ☐ / tongue problems ☐ / canker sores ☐
Other: _____ N/A ☐

Neck: Swollen glands ☐ / thyroid problems ☐ / Other: _____ N/A ☐

Chest: Chest pain ☐ / asthma ☐ / shortness of breath ☐ / cough ☐
Other: _____ N/A ☐

Heart: Murmurs ☐ / palpitations ☐ / valve problems ☐ / mitral valve prolapse ☐ / angina ☐
Other: _____ N/A ☐

Intestinal: Colitis ☐ / ulcer gastritis ☐ / Barrett's esophagus ☐ / polyps ☐ / constipation ☐
Constipation ☐ / abdominal pain ☐ / vomiting ☐ / black tarry stools ☐
Other: _____ N/A ☐

Urinary: Urinary problems ☐ / urinary frequency ☐ / burning ☐ / kidney stones ☐
Other: _____ N/A ☐

Genital: Infection ☐ / warts ☐ / herpes ☐ / impotence ☐ / sexual difficulty ☐
Other: _____ N/A ☐

Upper Extremity: Pain in arms ☐ / shoulder pain ☐ / elbow pain ☐ / wrist pain ☐
Other: _____ N/A ☐

Lower Extremity: Pain in legs ☐ / knee pain ☐ / back pain ☐ / ankle pain ☐ / tingling ☐
Other: _____ N/A ☐

Spine: Low back pain ☐ / neck pain ☐ / mid back pain ☐ / scoliosis ☐
Herniated disc ☐ / sciatica ☐
Other: _____ N/A ☐

Systemic: Weight loss ☐ / fever ☐ / night sweats ☐ / trouble sleeping ☐ / loss of energy ☐
Other: _____ N/A ☐

Skin: Rashes ☐ / skin discolorations ☐ / easy bruising ☐
Other: _____ N/A ☐

Neuro: Headache ☐ / convulsions ☐ / seizures ☐ / fainting ☐ / stroke ☐
Other: _____ N/A ☐

Psych: Depression ☐ / stress with excessive worry ☐ / anxiety ☐
Other: _____ N/A ☐

PATIENT SELF DETERMINATION QUESTIONNAIRE

In order to comply with the Omnibus Budget Reconciliation Act of 1990 and Chapter 745, Florida Statutes, please answer the following questions:

Declaration to Decline Life-Prolonging Procedure (LIVING WILL)

☐ I have made such a declaration.

☐ I have NOT made such a declaration.

Health Care Surrogate

☐ I have designated a Health Care Surrogate.

☐ I have NOT designated a Health Care Surrogate.

Durable Power of Attorney

☐ I have appointed a Durable Power of Attorney for Health Care decisions.

☐ I have NOT appointed a Durable Power of Attorney for Health Care decisions.

I have been provided with information regarding the PATIENT SELF DETERMINATION ACT.

_____ _____
Signature of Patient or Representative Date

YEARLY RECONFIRMATION

I acknowledge that this information remains accurate.

_____ _____ Signature of Patient or Representative Date	_____ _____ Signature of Patient or Representative Date
_____ _____ Signature of Patient or Representative Date	_____ _____ Signature of Patient or Representative Date
_____ _____ Signature of Patient or Representative Date	_____ _____ Signature of Patient or Representative Date
_____ _____ Signature of Patient or Representative Date	_____ _____ Signature of Patient or Representative Date

I have been provided with information regarding the PATIENT SELF DETERMINATION ACT, but decline to answer the above questions.

_____ _____
Signature of Patient or Representative Date

Vijay Desai, M.D.
Samir Kapoor, M.D.
Roshan Mahtani, M.D.

6830 Gall Blvd.
Zephyrhills, Florida 33542
Phone: (813) 783-3118
Fax: (813) 355-5036

Florida Medical Clinic
Your life. Our specialty.

INTERNAL MEDICINE
& PRIMARY CARE

Patient Name: ______________________ **Date of Birth:** ______________

Please list the complete name and address for all of your previous physicians. With a signed consent we will request your medical records from your previous physician and/or physicians. These records will become a part of your medical records here at Florida Medical Clinic.

Name of Physician: ______________________
Address: ______________________
City: ____________ **State:** ________ **Zip:** ________

Name of Physician: ______________________
Address: ______________________
City: ____________ **State:** ________ **Zip:** ________

Name of Physician: ______________________
Address: ______________________
City: ____________ **State:** ________ **Zip:** ________

Name of Physician: ______________________
Address: ______________________
City: ____________ **State:** ________ **Zip:** ________

Name of Physician: ______________________
Address: ______________________
City: ____________ **State:** ________ **Zip:** ________

Name of Physician: ______________________
Address: ______________________
City: ____________ **State:** ________ **Zip:** ________

Name of Physician: ______________________
Address: ______________________
City: ____________ **State:** ________ **Zip:** ________