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:

Allergy	Reaction
	Reaction:
	Reaction:
	Reaction:
	Reaction:
	Reaction:

Past Medical History (Personal):

Have you ever had any of the following illnesses?

	Yes	No
Alcohol Overuse		
Allergies (not including meds)		
Anemia		
Anxiety/Depression		
Arthritis		
Asthma		
Cancer		
Colitis		
COPD		
Colon Polyps		
Diabetes		
Frequent Kidney or Bladder Infections		
Frequent Lung infections		
Gout		
Hay Fever		
Heart Attack		
Other Heart Disease		
Hepatitis		
High Blood Pressure		

	Yes	No
High Cholesterol		
Kidney Disease		
Prostate Problems		
Rheumatic Fever		
Seizure Disorder		
Sexually Transmitted Diseases		
Shingles		
Sickle Cell Anemia		
Sleep Apnea		
Stomach Ulcers		
Stroke		
Thyroid Problems		
Tuberculosis		
Whooping Cough		
Osteoporosis		

Other: ______________________

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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			______________

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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: __________ Results: ____________________
Date 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-Raynaud’s: __________ Results: ____________________
Date of last PSA: __________ Results: ____________________

Immunizations:

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

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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 __________

INTERNAL MEDICINE & PRIMARY CARE

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

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Zephyrhills, Florida 33542
Phone: (813) 783-3118
Fax: (813) 355-5036

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:** ____________