Clermont Medical Center

Memory Crowley, D.O
Christopher Guzik, D.O.
Kelley Winfrey, D.O.
Michael Winfrey, D.O.
Ivan Negron, M.D.

1135 Lake Avenue, P.O. Box 121009
Clermont, Florida 34712-1009
(352) 394-4035

Carol Takis, PA-C
Sherri Stanford, PA-C

Patient History Form

Name: _____ Date: _____
Social Sec. No. _____ Sex: _____ Marital Status: _____
Address:_____City_____ State___ Zip:_____
Home Phone: (___)_____ Cell Phone: (___)_____Work: (___)_____
Birth Date: ___/___/____ Age: ____ Place of Birth: _____ Occupation_____
Email:_____ Pharmacy:_____
Please check appropriate box (es):

☐ African American ☐ Hispanic ☐ Mediterranean ☐ Asian
☐ Native American ☐ Caucasian ☐ Northern European ☐ Other _____

What medications are you taking now?

Medication Name	Dosage

List all vitamins and other supplements that you are taking.

Vitamins/Supplements Name	Dosage

❖ **Are you allergic to any medications?** No ☐ Yes ☐ yes, please list and reaction.

Medication	Reaction

Past Medical History and Current History:

ILLNESSES	WHEN	COMMENTS
Cancer		
Diabetes		
Heart Attack/Angina		
Heart Failure		
Stroke		
High blood fat (Cholesterol/Triglycerides)		
High blood pressure (Hypertension)		
Sleep Apnea		
Thyroid Disease		
Other(describe):		

For Men Only:

When was your last: (Please list the date)

Physical _____ Pneumonia injection _____

PSA (lab work) _____ Zostavax (Shingles) _____

Colonoscopy _____ Tetanus injection _____

Flu shot _____

For Women Only:

When was your last: (Please list the date)

Physical _____ Pneumonia injection _____

Pap Smear _____ Zostavax (Shingles) _____

Mammogram_____ Tetanus injection _____

Colonoscopy _____ DEXA (bone density test)_____

Flu Shot _____

Have you ever been pregnant? ____ No _____ Yes If yes:

Number of miscarriages _____ Number of abortions _____ Number of term births_____

Have you ever used birth control pills? _____No _____ Yes If yes, when:_____

Are you in menopause? _____No _____Yes If yes, age at last period _____

Do you take:

Estrogen?___ Ogen?____ Estrace?_____ Premarin?_____ Other (specify) _____

Progesterone? _____ Provera? _____ Other (Specify) _____

How long have you been on hormone replacement therapy (if applicable)? _____

Surgery History:

	Year	Comments
Appendectomy		
Dental Surgery		
Gallbladder		
Hernia		
Hysterectomy		
Tonsillectomy		
Other (describe):		

<u>Hospitalizations:</u> Please list only overnight hospitalizations other than surgery or child birth.

Where Hospitalized	When	For what reason

Family History:

Relative:	Age if alive	Age of death	Cause of death	hypertension	Cancer	Cardiac problems	Asthma	Diabetes	Alzheimer's or dementia
Father									
Mother									
Brothers									
Sisters									
Spouse									
Son									
Daughter									
Paternal Grandfather									
Paternal Grandmother									
Maternal Grandfather									
Maternal Grandmother									

Other diseases: _____
_____

- **Have you ever used tobacco**? _____No _____Yes Year quit: _____

If yes: every day? ____ some days, but not every day? _____

How many cigarettes a day?

___ 5 or less _____ 6-10 ____ 11-20 ____21-30 ____31 or more

How soon after you wake up do you smoke your fist cigarette?

____within 5 minutes ____6-30 minutes ____31-60 minutes ____ after 60 minutes

Are you interested in quitting?

____Ready to quit ____Thinking about quitting ____ Not ready to quit

Tobacco used other than smoking? _____No _____Yes

- **Did you have a drink containing alcohol in the past year**? ____No ____Yes

If yes how often:

____monthly or less ____2-4 times a month ____2-3 times a week ___4 or more times a week

How many drinks did you have on a typical day when you were drinking in the past year?

___ 1-2 drinks ___3-4 drinks ___5-6 drinks ____7-9 drinks ____10 or more drinks

How often did you have 6 or more drinks on one occasion in the past year?

___Never ____Less than monthly ____Monthly ____Weekly ____Daily or almost daily

Are you feeling down, depressed or hopeless? ____Yes _____No

Do you feel little interest or pleasure in doing things? _____Yes _____No

Have you ever used recreational drugs? ____No ___ Yes When?_____

How much Caffeine daily? _____

REVIEW OF SYMPTOMS: Please indicate if you have any of the following

General:

Fever Chills ___ Malaise___ Fatigue___ Night Sweats___ Headache___ Weight Change_____

Eyes:

Change in vision____ Blurring____ Double vision____ Pain____ Date of last eye exam:_____
Did they change your Rx? _____

Ears:

Hearing loss___ Pain___ Discharge___ Ringing___

Nose:

Loss of smell:_____ Obstruction _____

Throat:

Hoarseness (Change in voice)____ Frequent sore throats ____ Sore or bleeding gums____
Toothaches_____ Change in taste _____

Dentures:

Upper_____ Lower _____ Full _____ Partial _____

Endocrine:

Thyroid enlargement_____ Pain _____ Tenderness _____
Weight change_____ Heat or Cold Intolerance _____ Excessive Thirst_____

Respiratory:

Pain___ Shortness of breath___ Wheezing____ Cough____ Sputum Production_____
Coughing up blood____ Exposure to TB ____ Date last Chest X-ray_____ Reason_____

Cardiac:

Chest pain____ Palpitations_____ Ankle swelling____ Leg cramps____ High blood pressure_____
Other heart problems:_____Date of last ECG:_____other heart tests:_____

Gastrointestinal:

Change in appetite_____ Food intolerance_____ Heartburn_____ Nausea_____ Vomiting_____
Constipation_____ Diarrhea_____ Black or Bloody stools____ Gallstones____ Hernia ____
Ciarrhosis_____ Hepatitis_____ Jaundice _____

Hematology:

Anemia____ Bleeding problems_____ Blood clots _____
Transfusions_____ Date_____ Reasons_____

Female:

Breast lumps____ Breast Pain____ Discharge from the breast____
Menstruation: Heavy bleeding____ Irregular____ Missed menses____ Painful menses_____
Vaginal bleeding between periods_____ Vaginal discharge _____
Hotflashes_____ Painful intercourse_____ Infertility_____ Fibroids_____ Ovarian cyst_____
Endometriosis_____

Male:

Discharge from penis____ Ejaculation problem___ Genital pain___ Impotence____ Infection___
Lumps in testicles____ Poor libido (sex drive)____ Prostate enlargement____ Prostate infection____
Other prostate problem_____

Lymphatic:

Swollen Lymph Nodes_____ Pain_____

Urinary:

Kidney or Bladder Stones____ Urinary Tract Infection____ Blood in Urine____ Painful Urination____
Frequency____ Dribbling_____ Decrease in Force of Stream_____

Musculoskeletal:

Back pain___ Joint pain____ leg pain____ swelling in joints_____ Muscle spasm_____
TMJ problems_____ Weakness_____ Cramps_____

Skin:

Rash ____ Eruptions____ Itching_____ Color Change_____ abnormal hair or nail growth_____

Mental:

Stroke_____ Paralysis_____ Depression_____ Crying spells_____ Memory loss_____
Loss of balance _____ Suicidal thoughts _____

Please comment on any other information you feel the doctor should know or discuss with you.

_____

_____

_____

_____

_____

_____

_____