Clermont Medical Center

1135 Lake Avenue
Clermont, FL 34711
Ph: (352) 394-4035
Fax: (352) 394-8585

Christopher Guzik, D.O.
Ivan Negron, M.D.
Gary M. Winfrey, D.O.
Sherri Sanford, PA-C
Kelley Winfrey, D.O.
Shaunagh Cook, FNP-C

Patient History Form

Primary Care Physician: ______________________ Date: ______________

Patient Name: ______________________ DOB: ______________

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 If yes, please list and reaction

Medication		Reaction

Past Medical History and Current History:

Illness	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 ________________

PSA (lab work)________________

Colonscopy ________________

Flu Shot ________________

Lab Work ________________

Pneumonia injection ________________

Zostavax (Shingles) ________________

Tetanus injection ________________

For Women Only:

When was your last: (Please list the date)

Physical ________________

Pap Smear ________________

Mammogram ________________

Colonoscopy ________________

Flu Shot ________________

Lab Work ________________

Pneumonia injection ________________

Zostavax (Shingles) ________________

Tetanus injection ________________

DEXA (bone density test) ________________

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 If yes, age at last period: ________________

Do you take:

Estrogren? ______ 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):		

Hospitalizations: Please list only overnight hospitalizations other than surgery or child birth.

WHERE HOSPITALIZED	WHEN	FOR WHAT REASON

Physicians that you are currently seeing:

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 first 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? ☐ No ☐ Yes

Do you feel little interest or pleasure in doing things? ☐ No ☐ Yes

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:

Fevers 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 of 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 appetitie ______ 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 ______________________________

Lymphataic:

Swollent 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.

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