LAKE MARY Family Physicians
Our Family to Yours

Clinical Summary

Welcome to our practice. Please answer all the questions found below to the best of your ability.

Name: _____ **Date:** _____

Reason for today's visit: _____

Previous Hospitalization/Surgeries/Procedures:	**When:**	**Doctor:**
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you had a colonoscopy: **YES** or **NO** If so, when: _____ Doctor: _____
Allergies to any medications: _____

Please list your current medications and dosages:

1. _____	_____	5. _____	_____
2. _____	_____	6. _____	_____
3. _____	_____	**7.** _____	_____
4. _____	_____	**8.** _____	_____

Family Medical History:

	Illnesses	**If deceased, cause of death**
Mother:	_____	_____
Father:	_____	_____
Siblings:	_____	_____
Children:	_____	_____

Please check if any of the following symptoms recently trouble you:

General
___ fevers or sweats
___ undesired weight loss

Eyes
___ vision worsening
___ double vision

Ear, Nose, Throat
___ hearing loss
___ difficulty swallowing

Cardiovascular
___ chest pain
___ chest heaviness

Respiratory
___ short of breath
___ coughing up blood

Gastrointestinal
___ blood in stool
___ vomiting blood

Genitourinary
___ blood in urine
___ discharge

Musculoskeletal
___ joint swelling
___ muscle weakness

Skin
___ black moles
___ changing moles

Neurological
___ convulsions
___ falling

Psychiatric
___ lack of pleasure or fun
___ thoughts of suicide

Endocrine
___ hot flashes
___ can't tolerate cold temps

Hematology
___ bruising easily
___ bleeding frequently

Allergy
___ wheezing
___ nasal congestion

Sexual
___ sex life could be better

INSTRUCTIONS: This questionnaire will help us understand problems you may have. It may be necessary to ask you more questions about some of these items. Please make sure to circle **EVERY** items answer.

*During the **PAST MONTH**, have you been bothered **A LOT** by…*	*During the **PAST MONTH**…*

	Yes	No
stomach pain	Y	N
back pain	Y	N
pain in your arms, legs, or joints (knees, hips, etc.)	Y	N
menstrual pain or problems	Y	N
pains or problems during sexual intercourse	Y	N
headaches	Y	N
chest pain	Y	N
dizziness	Y	N
fainting spells	Y	N
feeling your heart pound or race	Y	N
shortness of breath	Y	N

	Yes	No
constipation, loose bowels, diarrhea	Y	N
nausea, gas, or indigestion	Y	N
feeling tired or having low energy	Y	N
trouble sleeping	Y	N
your eating being out of control	Y	N
little interest or pleasure in doing things	Y	N
feeling down, depressed or hopeless	Y	N
"nerves" or feeling anxious or on edge	Y	N
worrying about a lot of different things	Y	N

	Yes	No
have you had an anxiety attack (suddenly feeling fear or panic)	Y	N
have you thought you should cut down on your drinking of alcohol	Y	N
has anyone complained about your drinking	Y	N
have you felt guilty or upset about your drinking	Y	N
was there ever a single day in which you had five or more drinks of beer, wine or liquor	Y	N

Overall, would you say your health is:

Excellent _____
Very good _____
Good _____
Fair _____
Poor _____

FOR WOMEN ONLY

1. Last Pap Smear: _____ Do you have a GYN: _____ if so, who_____
2. Are your periods normal: _____
3. Number of vaginal deliveries: _____ C-Sections: _____
4. Last Mammogram: _____
5. Last Bone Density Screening: _____