Florida Surgical Clinic

701 Manatee Ave. W. Suite 105
Bradenton, FL 34205-8624

Phone: 727-SURGERY
Phone: 727-787-4379

Office Fax: 727-228-4542
EHR Fax: 877-418-8527

www.floridasurgicalclinic.com

Initial Patient History Questionnaire

Please complete and bring this form with you to your first appointment.

Patient Name: _____ Todays Date: _____

Referring Physician: _____ Birth Date: _____ Age: _____

Any/All others doctors you see: _____

HISTORY OF PRESENT ILLNESS

- Location: _____ Duration: _____
  (Where on the body symptom occurs) (How long have you had symptom? Last time?)
- Severity: _____ Quality: _____
  (Severe, Worse, Slightly. Pain scale 1-10) (Character of symptoms? Burning, Aching, Sore)
- Timing: _____ Context: _____
  (When does the symptoms occur?) (What's the situation associated with symptoms?)
- Modifying Factors: _____
  (What makes the symptoms better or worse? i.e. specific movement, medication)
- Associated Signs/Symptoms: _____
  (Other things that happen when this symptom occurs)

MEDICAL HISTORY, FAMILY HISTORY, & SOCIAL HISTORY

Medical History: Please circle the correct answer for the following medical conditions.

High Blood Pressure	Yes	No	Diabetes	Yes	No	Heart Trouble	Yes No
Respiratory Problems	Yes	No	Stroke	Yes	No	Cancer	Yes No
Bleeding Problems	Yes	No	Other problems	_____			

What is your current weight? _____ **Height?** _____

Current Medications: _____

_____

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DRUG ALLERGIES: _____

Past Hospitalizations/Surgeries/Injuries and Approximate Dates:

_____

_____

FAMILY HISTORY: Please list any medical problems in your relatives.

Father:_____ Mother:_____ Siblings:_____

Others:_____

SOCIAL HISTORY: **Marital Status**: Single Married Separated Divorced Widowed

Tobacco Use: Never Quit/When: _____ Daily/How much?_____

Alcohol Use: Never Rarely Moderate Daily/How much?_____

Drug Use: Never Rarely Moderate Daily/How much?_____

Occupation:_____

REVIEW OF SYSTEMS: Please circle the correct answer for the following medical conditions.

Constitutional			**Ears/Nose/Mouth/Throat**			**Eyes**		
Good General Health	Yes	No	Hearing loss/Ringing	Yes	No	Wear glasses/contacts	Yes	No
Recent weight change	Yes	No	Sinus Problems	Yes	No	Blurred/double vision	Yes	No
Night sweets/fevers	Yes	No	Nose bleeds	Yes	No	Eye Disease or injury	Yes	No
Fatigue	Yes	No	Sore throat/voice loss	Yes	No	Glaucoma	Yes	No

Cardiovascular			**Respiratory**			**Gastrointestinal**		
Chest Pain	Yes	No	Shortness of breath	Yes	No	Nausea/vomiting	Yes	No
Palpitations	Yes	No	Cough	Yes	No	Abdominal pain	Yes	No
Heart Trouble	Yes	No	Wheezing/asthma	Yes	No	Rectal bleeding	Yes	No
Swelling hands/feet	Yes	No	Coughing up blood	Yes	No	Bowel problems	Yes	No

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Musculoskeletal			**Neurological**			**Integumentary**		
Muscle pain or cramp	Yes	No	Frequent headaches	Yes	No	Change in hair or nail	Yes	No
Stiffness swelling joints	Yes	No	Paralysis or tremors	Yes	No	Rashes or itching	Yes	No
Joint pain	Yes	No	Convulsions/Seizures	Yes	No	Breast Lump	Yes	No
Trouble walking	Yes	No	Numbness/tingling	Yes	No	Breast pain/discharge	Yes	No

Endocrine			**Hematologic/Lymphatic**			**Allergic/Immunologic**		
Excessive thirst/urination	Yes	No	Bruise easily	Yes	No	Food Allergies	Yes	No
Thyroid disease	Yes	No	Slow to heal	Yes	No	Aspirin allergies	Yes	No
Hormone problem	Yes	No	Enlarged glands	Yes	No	Antibiotic allergies	Yes	No

Genitourinary	**Male only**		**Genintourinary**	**Female Only**		**Psychiatric**		
Blood in urine	Yes	No	Blood in urine	Yes	No	Insomnia	Yes	No
Kidney stones	Yes	No	Kidney stones	Yes	No	Confusion	Yes	No
Sexual problems	Yes	No	Sexual Problems	Yes	No	Depression	Yes	No
Testicle pain	Yes	No	Menstrual problems	Yes	No	Memory loss	Yes	No

PATIENT STATEMENT: To the best of my knowledge, the above information is accurate and complete

Signed:_____Date:_____

PHYSICIAN STATEMENT: I have reviewed the questionnaire with the patient

Signed:_____Date:_____