Lakeland Primary Care: University Medical Specialties

Adult Medical Information Sheet

Please print legibly.

Name:	Date:
	Date of last complete physical:

Questions or Concerns for the doctor:

1. ______________________________
2. ______________________________
3. ______________________________

Allergies or sensitivities **to medicines or other substances** (Note type of reaction) ☐ None

Medicines (please include all vitamins, herbs and supplements, use an additional page if necessary) ☐ None

Medicine	*Dose*	*Times a day*	*Medicine*	*Dose*	*Times a day*
1.			7.		
2.			8.		
3.			9.		
4.			10.		
5.			11.		
6.			12.		

YOUR Medical History

Ongoing Illness/Disease	Year began	Surgery/Injury	Year

Have you ever had?

- ☐ Asthma/Emphysema
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Heart Attack
- ☐ Stroke
- ☐ Blood Clots/Phlebitis
- ☐ Aneurysm
- ☐ Fibromyalgia
- ☐ Osteoarthritis
- ☐ Gout
- ☐ Immune/Autoimmune
- ☐ Colitis ________
- ☐ Ulcer
- ☐ Colon Polyps
- ☐ Kidney Disease
- ☐ Kidney Stone
- ☐ Skin Cancer ________
- ☐ Abnormal Moles
- ☐ Breast Cancer
- ☐ Prostate Cancer
- ☐ Other Cancer ________
- ☐ Blood Disorder
- ☐ Epilepsy
- ☐ Migraine
- ☐ Depression/Anxiety
- ☐ Other Mental Illness
- ☐ Liver Disease
- ☐ Rheumatic Fever
- ☐ Tuberculosis
- ☐ Polio
- ☐ Chicken Pox
- ☐ HIV/AIDS
- ☐ Syphilis
- ☐ Genital Herpes
- ☐ Gonorrhea
- ☐ Other STD ________

Previous Studies/Date (bring copies of recent tests results and imaging reports if pertinent)

- ☐ Pulmonary Function ________
- ☐ Bronchoscopy ________
- ☐ Echocardiogram ________
- ☐ Stress Test ________
- ☐ Heart Catheterization ________
- ☐ Upper Endoscopy ________
- ☐ Flexible Sigmoidoscopy ________
- ☐ Kidney IVP ________
- ☐ Colonscopy ________
- ☐ Bone Density ________
- ☐ CAT Scan of ________
- ☐ Last Mammogram ________
- ☐ MRI of ________
- ☐ Ultrasound of ________
- ☐ Biopsy of ________
- ☐

FAMILY Medical History (DO NOT INCLUDE YOURSELF) Include grandparents, aunts, uncles, cousins, parents, siblings, kids. **Note who & approximate age of diagnosis/occurance.**

- ☐ Stroke
- ☐ Heart Attack/Angioplasty
- ☐ Heart Surgery
- ☐ High Blood Pressure
- ☐ Aneurysm: ☐ Brain ☐ Chest ☐ Abdomen
- ☐ Diabetes
- ☐ Inflammatory Arthritis
- ☐ Thyroid Disease
- ☐ Kidney Stone
- ☐ Kidney Disease
- ☐ Bleeding Tendency
- ☐ Blood Clots: ☐ Legs ☐ Lungs
- ☐ Glaucoma
- ☐ Liver Disease
- ☐ Colitis
- ☐ Colon Cancer
- ☐ Colon Polyps
- ☐ Breast Cancer
- ☐ Prostate Cancer
- ☐ Other Cancer
- ☐ Asthma
- ☐ Tuberculosis
- ☐ Depression/Anxiety
- ☐ Epilepsy
- ☐ Migraine
- ☐ Osteoporosis
- ☐ Alcoholism/Drug Abuse
- ☐ Other ________

Social Information

Tobacco (current): Yes No Date Quit ________ Amount per day ________ How many years? ________

Alcohol (current): Yes No Amount per week ________

Have you had a problem with alcohol in the past? Yes No

Drugs (marijuana, cocaine, etc.): Yes No If yes, type & date of last use ________

Travel in the last 2 years (when & where to): ________

Internationsl Travel (all, not just recently): ________

Military Service (when & where served): ________

Exposure to hazardous materials: Yes No If so, list types: ________

Diet (any special diet): ☐ None ☐ Lacto-Ovo Vegetarian ☐ Vegan ☐ Other ________

Caffeine (coffee, tea or soda): Yes No Amount per day ________

Exercise: Yes No Type: ________ Number of times a week ________

Current Occupation (if retired, last occupation): ________ ☐ Retired

Are you on disability: Yes No Reason for disability: ________

Marital Status (circle one): Single Married Remarried Divorced Widowed Legally Separated

Spouse's Name: ________ Number of Children: ________

Vaccines (list date if known)

Tetanus	Chicken Pox (Varicella)	BCG
Flu	Hepatitis A	Shingles (Zostavax)
Pneumonia (Pneumovax)	Hepatitis B	Other

Names and specialties of other doctors you are seeing: ____________________

____

Do you CURRENTLY have any of the following:

General

- ☐ Frequent fevers, chills, night sweats
- ☐ Unusual fatigue or daytime sleepiness
- ☐ Generally feeling unwell much of the time
- ☐ Recent weight loss or gain (circle & list amount)
- ☐ Frequent difficulty sleeping
- ☐ Snoring
- ☐ Want to be tested for HIV/AIDS

Mental/Emotional Health

- ☐ Feel anxious or experience panic attacks
- ☐ Having problems with concentration or focus
- ☐ Feel depressed, blue, sad or down much of the time
- ☐ Stress or frequent conflicts at home or at work (circle)
- ☐ Experience obsessive or compulsive thoughts
- ☐ I am being hit, slapped, and/or kicked at home
- ☐ Have experienced physical abuse in the past
- ☐ I am being touched inappropriately or forced to have sex
- ☐ Have experienced sexual abuse or rape in the past
- ☐ Seriously considered or tried to commit suicide
- ☐ History of hospitalization for an emotional problem

Ears, Eyes, Nose, Throat

- ☐ Blurred/Decreased Vision
- ☐ Double Vision
- ☐ Dry Eyes
- ☐ Excessive Tearing
- ☐ Eye pain
- ☐ Eyes are overly sensitive to light
- ☐ Significant increase in floaters
- ☐ Frequent or severe nosebleeds
- ☐ Recent change in hearing
- ☐ Nasal Congestion/Runny Nose
- ☐ Lip/Mouth Sores
- ☐ Sinus Pain
- ☐ Sneezing
- ☐ Sore Throat
- ☐ Dental/Tongue Problem
- ☐ Ringing in Ears ☐ New ☐ Chronic
- ☐ Use a hearing aid
- ☐ Hoarseness
- ☐ Itching eyes

Heme/Lymphatic

- ☐ Have had a blood clot
- ☐ Easily bruising
- ☐ Swollen Lymph Nodes
- ☐ Have had a blood product transfusion (when ________)
- ☐ Bleed easily or have history of bleeding problems

Lungs/Cardiovascular

- ☐ Chronic cough (greater than 1 month)
- ☐ Coughing up blood
- ☐ Difficulty breathing well while laying flat
- ☐ Chest/Back pain when you take a deep breath
- ☐ Short of breath just sitting
- ☐ Wheezing
- ☐ Chest pain or pressure, describe
- ☐ Unusual shortness o breath when hurrying or walking up 2 flights of stairs
- ☐ Frequently swollen ankles NOT related to injury
- ☐ Irregular heart beat, palpitations or rapid heart beat
- ☐ Awaken short of breath during night
- ☐ Pain or tiredness in legs while walking
- ☐ Recent blood pressure reading (before today)
- ☐ Heart Murmur
- ☐ Have to take antibiotics before procedures

Gastrointestinal

- ☐ Abdominal pain (location)
- ☐ Loss of appetite (not related to nausea)
- ☐ Black (tarry) or bloody bowel movements
- ☐ Recent change in bowel habits, describe
- ☐ Chronic/frequent constipation
- ☐ Frequent heartburn (times per week ________)
- ☐ Vomiting up blood
- ☐ Stool incontinence
- ☐ Nausea/vomiting
- ☐ Difficulty or pain with swallowing ☐ Solids ☐ Liquids
- ☐ Chronic/frequent diarrhea
- ☐ Excessive gas or bloating

Endocrine

- ☐ Excessive thirst
- ☐ Usually feel too hot or too cold (circle)
- ☐ Changes in hair pattern (i.e. excessive facial hair, scalp balding, balding on other areas of the body)

Musculoskeletal

- ☐ Gait disturbance, describe
- ☐ Persistent joint pain (if so list which joints)
- ☐ Perisitent joint stiffness
- ☐ Back pain ☐ New ☐ Chronic
  - ☐ Associated with shooting pain, numbness or tingling of one or both legs
- ☐ Joint swelling (if so list which joints)
- ☐ Muscle pain
- ☐ Muscle weakness
- ☐ Neck pain ☐ New ☐ Chronic
  - ☐ Associated with shooting pain, numbness or tingling of one or both arms

Neurologic

- ☐ New, frequent or severe headaches (circle)
- ☐ Falls or imbalance (circle)
- ☐ Memory loss
- ☐ Weakness, numbness or tingling in arms or legs
- ☐ Speech problems
- ☐ Tremors
- ☐ Fainting
- ☐ Restless legs at night (not due to pain)
- ☐ Convulsions (seizures)
- ☐ Frequent dizziness

Skin

- ☐ Acne
- ☐ Dry Skin
- ☐ Eczema
- ☐ Itching
- ☐ Nail Changes
- ☐ Rash
- ☐ Irregular, enlarging, itching, multi-colored or bleeding moles

Women Only

- ☐ Breast lump or nipple discharge (circle)
- ☐ Do your own breast self exams
- ☐ Change in menstual cycle, describe
- ☐ Severe pain with periods
- ☐ Pain or dryness during intercourse
- ☐ Irregular menstrual periods
- ☐ Current pain with urination, unusual frequency or urgency
- ☐ Hot flashes
- ☐ Mood swings
- ☐ Sexual problems or change in sex drive
- ☐ Date of last pap ______________
- ☐ History of abnormal pap ______________
- ☐ Vaginal discharge, burning or itching
- ☐ Genital sores/ulcers
- ☐ Blood in urine
- ☐ Loss of control of urine at times
- ☐ Heavy or prolonged bleeding with periods
- ☐ Method of birth control ______________
- ☐ Think you might be pregnant, or trying
- ☐ Bleeding after menopause
- ☐ Ever used hormone replacement
- ☐ Date of last menstrual period
- ☐ Number of: pregnancies _____ deliveries _____ miscarriages _____ abortions _____

Men Only

- ☐ Problems with urinary stream
- ☐ Pain with urination
- ☐ Erectile dysfunction (impotence)
- ☐ Discharge from the penis
- ☐ Sores/ulcers on the penis or around the anus
- ☐ Blood in the urine
- ☐ Urine incontinence
- ☐ Awaken frequently during the night to urinate
- ☐ Abnormal mass in scrotum
- ☐ Urinary frequency/urgency
- ☐ Change in sex drive
- ☐ Do your own testicular self exams
- ☐ Date of last prostate exam or blood test for
- ☐ prostate cancer ______________

Miscellaneous ☐ Have a Living Will or Durable Power of Attorney for Healthcare (if so, please bring paperwork)