Florida Medical Clinic
Your Life, Our Specialty

Lisa A. Scudder, D.O. • Family Medicine
10004 North Dale Mabry Highway, Suite 101 • Tampa, Florida 33618
Phone: 813.931.3999 • Fax: 813.377.1391

Patient Personal History & Health Assessment

Name: _____ **Today's Date:** _____

DOB: _____ **Age:** _____

Reason for Visit: **Please check all that apply**

☐ Establish with a new Primary Care Physician
☐ Re-establish - Was a previous patient
☐ Problems / Complaints to discuss today:

_____
_____
_____

Who referred you here? _____

Do you take any prescription medications?

☐ No
☐ Yes - Please list names / dosages / frequency

_____
_____
_____
_____
_____
_____

Do you take daily vitamins / supplements?

☐ No
☐ Yes

_____
_____

Are you allergic to any medicines?

☐ No
☐ Yes

_____
_____

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Past Medical History (Personal): **Please check all that apply**

- ☐ Alcohol Overuse _____
- ☐ Allergies - Environmental / Seasonal _____
- ☐ Anemia _____
- ☐ Anxiety _____
- ☐ Arthritis _____
- ☐ Asthma _____
- ☐ Cancer _____
- ☐ Colitis _____
- ☐ COPD _____
- ☐ Colon Polyps _____
- ☐ Diabetes _____
- ☐ Depression _____
- ☐ Gout _____
- ☐ Heart Disease _____
- ☐ Hepatitis _____
- ☐ Hypertension _____
- ☐ High Cholesterol _____
- ☐ Insomnia / Trouble Sleeping _____
- ☐ Kidney Problems _____
- ☐ Prostate Problems _____
- ☐ Sleep Apnea _____
- ☐ Stroke _____
- ☐ Thyroid Disease _____
- ☐ Osteoporosis / Osteopenia _____

Other: _____

_____

_____

_____

_____

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Past Surgeries:

_____ Year _____
_____ Year _____
_____ Year _____
_____ Year _____

Hospitalizations / Serious Injuries:

_____ Year _____
_____ Year _____
_____ Year _____

Family History:

Mother ☐ Living Age _____
Medical problems: _____
_____
☐ Deceased Age _____ Cause _____

Father ☐ Living Age _____
Medical problems: _____
_____
☐ Deceased Age _____ Cause _____

Brothers _____
_____

Sisters _____
_____

Maternal Side: Aunts / Uncles _____
_____
Grandparents _____
_____

Paternal Side: Aunts / Uncles _____
_____
Grandparents _____
_____

Other _____
_____
_____

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Social History:

☐ Married ☐ Widowed ☐ Divorced
☐ Single - Not in a relationship ☐ Single - In a relationship
Sexually active? ☐ Never ☐ Yes ☐ Not currently

Employment:

☐ Full-time ☐ Part-time ☐ Currently not working
☐ Retired ☐ Legally disabled - since _____
Student? ☐ No ☐ Yes F/T ☐ Yes P/T

Exercise:

☐ Yes - _____ times per week
☐ No exercise
☐ Variable

Caffeine Use: ☐ No caffeine ☐ Yes - Check all that apply

☐ Coffee ☐ Soda ☐ Tea ☐ Energy Drinks
How many servings per day? _____

Tobacco Use: ☐ Never smoked

☐ Previous smoker - Quit _____ years ago.
☐ Currently smoke - For _____ years.
How many cigarettes per day? _____
Smokeless tobacco? ☐ Yes ☐ No

Alcohol Use: ☐ No alcohol

☐ Social - How many drinks per week? _____
☐ Daily - How many drinks per day? _____
☐ Recovering alcoholic - Sober for _____ years.

Drug Use: ☐ No history of drug use

☐ Yes, have used drugs in the past - ☐ Marijuana ☐ Heroin ☐ Cocaine ☐ Other
☐ Yes, currently use _____
Have you ever abused prescription drugs? ☐ Yes ☐ No

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FEMALES OB /GYN History:

How many pregnancies have you had? _____

How many live births? _____

Vaginal or C/Section

How many miscarriages / abortions? _____

Any complications during any pregnancies? _____

_____

Menstrual History:

Age you started menses _____

Are you still menstruating? _____

If yes, are your periods regular / irregular?

Last menstrual period _____

If no, when did you stop menstruating? _____

FEMALES Preventative Screenings:

Last mammogram _____ Results _____

Last dexascan _____ Results _____

Last pap / well woman exam _____ Results _____

Last colonoscopy _____ Results _____

Last routine labs _____ Results _____

Last routine physical _____ Results _____

Last chest x-ray _____ Results _____

Last cardiac stress test _____ Results _____

Last eye exam _____ Results _____

Last tetanus vaccine _____

Last shingles vaccine _____

Last pneumococcal vaccine _____

Have you had HPV vaccine? _____

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MALES Preventative Screenings:

Last colonoscopy _____ Results _____

Last routine labs _____ Results _____

Last routine physical _____ Results _____

Last PSA (prostate blood test) _____ Results _____

Last chest x-ray _____ Results _____

Last rectal exam / prostate check _____ Results _____

Last cardiac stress test _____ Results _____

Last eye exam _____ Results _____

Last tetanus vaccine _____

Last shingles vaccine _____

Last pneumococcal vaccine _____

DIABETICS

Last diabetic foot exam _____

Last diabetic eye exam _____

Last HbA1C _____

CHILDREN (<18 years of age)

Grade _____

School _____

Play sports? _____

Last dental exam _____

Immunizations: ☐ Up to date

☐ Currently not up to date

☐ Never immunized

☐ Not sure