



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 <input type="checkbox"/> fevers or sweats <input type="checkbox"/> undesired weight loss Eyes <input type="checkbox"/> vision worsening <input type="checkbox"/> double vision Ear, Nose, Throat <input type="checkbox"/> hearing loss <input type="checkbox"/> difficulty swallowing Cardiovascular <input type="checkbox"/> chest pain <input type="checkbox"/> chest heaviness Respiratory <input type="checkbox"/> short of breath <input type="checkbox"/> coughing up blood	Gastrointestinal <input type="checkbox"/> blood in stool <input type="checkbox"/> vomiting blood Genitourinary <input type="checkbox"/> blood in urine <input type="checkbox"/> discharge Musculoskeletal <input type="checkbox"/> joint swelling <input type="checkbox"/> muscle weakness Skin <input type="checkbox"/> black moles <input type="checkbox"/> changing moles Neurological <input type="checkbox"/> convulsions <input type="checkbox"/> falling	Psychiatric <input type="checkbox"/> lack of pleasure or fun <input type="checkbox"/> thoughts of suicide Endocrine <input type="checkbox"/> hot flashes <input type="checkbox"/> can't tolerate cold temps Hematology <input type="checkbox"/> bruising easily <input type="checkbox"/> bleeding frequently Allergy <input type="checkbox"/> wheezing <input type="checkbox"/> nasal congestion Sexual <input type="checkbox"/> sex life could be better
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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.

<i>During the PAST MONTH, have you been bothered A LOT by...</i>			<i>During the PAST MONTH...</i>					
	Yes	No		Yes	No		Yes	No
stomach pain	Y	N	constipation, loose bowels, diarrhea	Y	N	have you had an anxiety attack (suddenly feeling fear or panic)	Y	N
back pain	Y	N						
pain in your arms, legs, or joints (knees, hips, etc.)	Y	N	nausea, gas, or indigestion	Y	N	have you thought you should cut down on your drinking of alcohol	Y	N
menstrual pain or problems	Y	N	feeling tired or having low energy	Y	N	has anyone complained about your drinking	Y	N
pains or problems during sexual intercourse	Y	N	trouble sleeping	Y	N			
headaches	Y	N	your eating being out of control	Y	N	have you felt guilty or upset about your drinking	Y	N
chest pain	Y	N				was there ever a single day in which you had five or more drinks of beer, wine or liquor	Y	N
dizziness	Y	N	little interest or pleasure in doing things	Y	N			
fainting spells	Y	N	feeling down, depressed or hopeless	Y	N	Overall, would you say your health is:		
feeling your heart pound or race	Y	N				Excellent _____		
shortness of breath	Y	N	“nerves” or feeling anxious or on edge	Y	N	Very good _____		
			worrying about a lot of different things	Y	N	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: _____