TAMPA BAY
Weight Loss Clinic

PERSONAL HISTORY

Name:_____Date_____S.S.#_____

Address:_____

City: _____ State _____ Zip code _____

Home phone _____ Cell _____ Other:_____E-Mail_____

Date of Birth _____ Age _____ Sex ☐ Male ☐ Female

Business/Employer _____

Address _____

Type of Work _____ Years Employed _____

Check One ☐ Married ☐Single ☐ Widowed ☐ Separated ☐ Divorced ☐ # of Children _____

Name of Emergency Contact _____ Relation _____ Phone _____

Who is responsible for your bill? ☐ Self ☐ Spouse ☐ Workmans' Comp ☐ Medicare ☐ Medicaid ☐ Auto ☐ Commercial

☐ Personal Health Insurance ☐ Other _____

Please answer the following Government Question:

What is your race: ☐ Caucasian ☐ Black ☐ Asian ☐ Pacific Islander ☐ Hispanic ☐ Refused to answer

What is you Religion: _____ What is your Native language? _____

CURRENT HEALTH CONDITION

Purpose of this Appointment _____

_____

Hospital or doctors seen for this condition _____

_____

When & how did this condition begin (describe)_____

_____

If disabled from work please give dates_____

☐ Job related ☐ Auto related ☐ Other_____

Are you presently taking any medication ☐ Yes ☐ No _____

_____

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Patient History

Patient Name:_____ Date:_____

Date of Birth:_____

Domestic Situation

With whom are you living?_____

Are there any substance abuse issues in the household? ☐Yes ☐No

Are you able to take care of yourself? ☐Yes ☐No

If not, please enter the name of your caregiver_____

Work History

How many Job Years did you worked?_____ Why did you leave?_____

Legal Matters

Are you presently involved in a lawsuit? ☐Yes ☐No If yes please explain

_____

Substance use

Which of the following drugs or substances, if any, have you used in the past? (Mark all that applies)

	Occasionally	frequently	continuously	in the past	present
Alcohol					
Cocaine					
Heroin,					
Barbiturates					
Amphetamines					
Marijuana					
Other-					

Do you presently smoke cigarettes or use tobacco in any form? ☐Yes ☐No

If not, did you ever smoke cigarettes or used tobacco in any form? ☐Yes ☐No

For how many years? _____ How many years ago did you quite? _____

How many packs do (did) you smoke a day? _____

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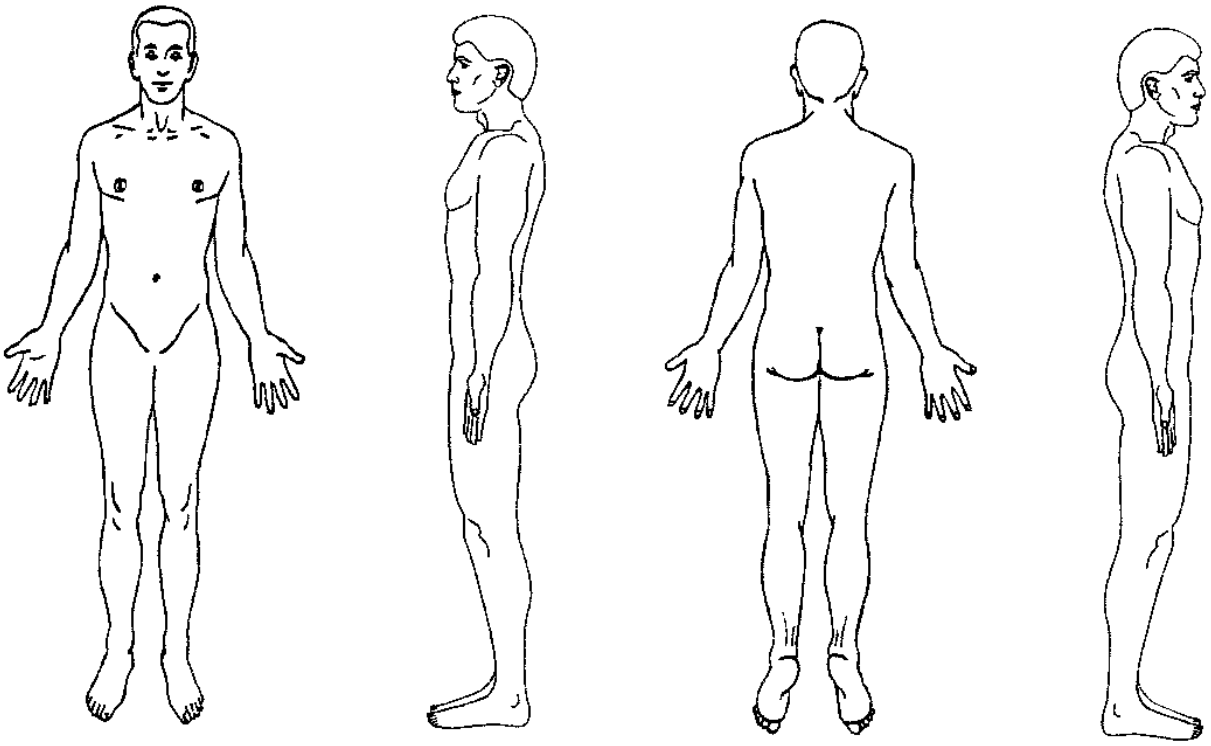
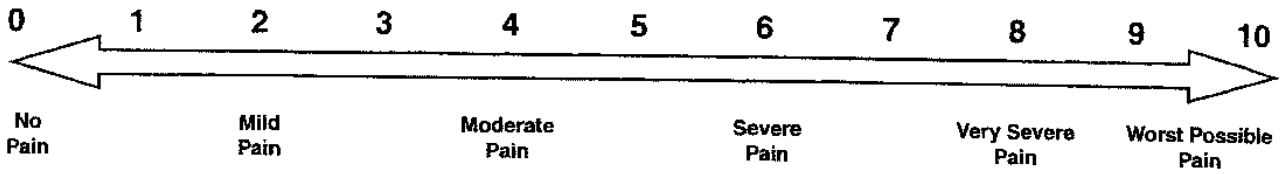
PAIN HISTORY & ASSESSMENT

Patient Name: _____ Age: _____ Date: _____

1. Please circle the areas of your body where you feel pain:



2. In the circles you've drawn, please indicate the intensity of pain with a number that corresponds to the scale below:



3. Please answer the following questions:

	Yes	No	Please Describe
Are you in pain today?	☐	☐	_____
Is the pain always there?	☐	☐	_____
Does it get worse when you move in certain ways?	☐	☐	_____
Do other things make it better or worse?	☐	☐	_____

Has your pain effected: ☐ Mobility ☐ Sleep ☐ Work ☐ Exercise ☐ Concentration ☐ Appetite ☐ Social Activities ☐ Relationships with others ☐ Emotions ☐ Other: _____

Please describe all past treatments for your pain including over-the-counter and prescription medications, herbal and vitamin supplements, surgery and alternative therapy:

_____

_____

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Medical History

Past Medical History

Please check if you have had any of the following:

□ Alcoholism
□ Anemia
□ Anxiety
□ Arrhythmia
□ Arthritis
□ Asthma
□ Atrial Fibrillation
□ Bronchitis
□ CAD
□Cancer Type:_____
□ Cardiovascular Disease
□ CHF
□ Crohn's Disease
□ Cirrhosis
□ Colitis
□ Constipation
□ COPD
□ CRF
□Other_____
□ CVA
□ Dementia / Alzheimer's
□ Disc Disease
□ DJD
□ Depression
□ DM Type I
□ DM Type II
□ Emphysema
□ Epilepsy
□ Fracture
□ GERD
□ Glaucoma
□ Hepatitis
□ High Cholesterol
□ Hyperlipidemia
□ Hypertension
□ Implanted Medical Devices
□ Kidney Disease
□ Allergies _____
□ Liver Disease
□ Migraine
□ Multiple Sclerosis
□ Nephrolithiasis
□ Obesity
□ Osteoarthritis
□ Osteoporosis
□ Prior MI
□ Pulmonary Disease
□ Rheumatoid Arthritis
□ Seizures
□ Sickle Cell Disease
□ STD
□ Thyroid Disease
□ TIA
□ Tuberculosis
□ Ulcers
□ Valve Problems
Reaction _____

Is there any chance you may be pregnant? □ Yes □ No Last date of menses: _____

Past Surgical History

Please check if you have had any of the following:

□ No prior surgical history
□ Appendectomy
□ D&C
□ Hysterectomy
□ Knee Arthroscopy
□ Mastectomy
□ Shoulder surgery
□ Spinal Surgery
□Tonsillectomy
□ Total Knee Replacement
□ Total Hip Replacement
□ Tubal Ligation
□ Other _____

Preventive Care

Have you had any of the following? If so, please provide the date.

□ Last Complete Physical Exam ___/___/___
□ Colonoscopy ___/___/___
□ Flexible Sigmoidocopy ___/___/___
□ PSA ___/___/___
□ Stool Occult Blood ___/___/___
□ Stress Test ___/___/___
□ Routine Eye Exam ___/___/___
□ Dilated Eye Exam ___/___/___
□ Foot Exam ___/___/___
□ HPV
□ Other _____
□ Bone Density ___/___/___
□ Mammography ___/___/___
□ Chlamydia Screening ___/___/___
□ HIV Testing ___/___/___
□ Flu Vaccine ___/___/___
□ Pneumovax ___/___/___
□ Zoster Vaccine ___/___/___
□ Tdap Vaccine ___/___/___
□ TD ___/___/___
□ Tuberculin PPD ___/___/___

General Family History

□ Ankylosing Spondylitis
□ Arthritis
□ Alcoholism
□ Anemia
□ Anxiety
□ Asthma
□ Bleeding Disorder
□ CAD
□ MI's
□ CHF
□ Other _____
□ Colitis
□ COPD
□ Crohn's Disease
□ CVA / TIA
□ Depression
□ Diabetes
□ Epilepsy
□ GERD
□ Gout
□ Hypertension
□ Kidney Disease
□ Liver Disease
□ Osteoarthritis
□ Osteoporosis
□ Psoriasis
□ Pulmonary Disease
□ Renal Disease
□ Rheumatoid Arthritis
□ SLE
□ Thyroid Disease

Name:_____ Date:_____

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Review of Systems

Please check if you have the following symptoms:

Constitutional

□ Loss of appetite □ Recent change in weight □ Fatigue (Tired)
□ Fever □ Chills □ Night Sweats
□ Able to perform ADL's independently □ Change in sleep habits
□ Other symptoms _____

Head & Neck

□ Headache □ Vision Problems □ Eye Pain
□ Ear pain □ Hearing difficulty □ Sinus Problems
□ Difficulty Swallowing □ Neck Stiffness □ Goiter
□ Other symptoms _____

Cardiovascular

□ Chest Pain □ Ankle edema □ Cold hands or feet
□ Palpitations □ Heart murmur □ Claudication
□ Other symptoms _____

Respiratory

□ Persistent cough □ Productive cough □ Shortness of breath
□ Dyspnea (Difficulty Breathing) □ Orthopnea □ Chest congestion
□ Other symptoms _____

Gastrointestinal

□ Nausea □ Vomiting □ Diarrhea
□ Constipation □ Hematochezia □ Abdominal Pain
□ Other symptoms _____

Genitourinary

□ Frequency □ Burning on urination □ Incontinence
□ Hesitancy □ Dysuria □ Urgency
□ Other symptoms _____

Endocrine

□ Polyuria (Frequent Urination) □ Polydysia (Excessive Thirst) □ Sexual Complaints
□ Heat intolerance □ Cold intolerance
□ Other symptoms _____

Musculoskeletal

□ Joint Pain □ Radiculopathy □ Fractures
□ Back Pain □ Joint Stiffness □ Sudden unexplained fractures
□ Other symptoms _____

Neurological

□ Ataxia □ Seizures □ Dizziness
□ Numbness □ Tingling □ Confusion
□ Speech Difficulties □ Motor Disturbances □ Sensory Disturbances
□ Other symptoms _____

Psychiatric

□ Anxiety □ Depression □ Panic Attacks
□ Suicidal Thoughts □ Suicide Attempts □ Sleep Disturbances
□ Mood Disorders □ Emotional Problems □ Depression Screening Completed
□ Other symptoms _____

Hematology / Immunology

□ Easy Bleeding tendency □ Easy Bruising tendency □ Swollen Nodes
□ Environmental Allergies □ Frequent Infections □ Food Allergy
□ Other symptoms _____