PRIMARY CARE SPECIALISTS OF FLORIDA

721 W COLONIAL DR, ORLANDO, FL 32804
Tel: (407) 735-6735, Fax: 1-855-618-2347

ADULT CLINICAL SUMMARY

Please update any changes since your last visit here

Name: ________________________________ **Date:** ______________

Reason for today's visit: ________________________________

____

Present medications and dose: ________________________________

____

Allergies: ________________________________

Are you allergic to latex? ☐ NO ☐ YES

Prior Surgeries: ________________________________

Hospitalizations and illnesses: ________________________________

____

I live ☐ alone ☐ with family ☐ with friends ☐ in a group home

I smoke ☐ never ☐ ______ packs per day ☐ ______ cigarettes per day
☐ quit smoking (year) __________ ☐ ______ cigars or pipe only

I drink alcohol ☐ every day ☐ every week ☐ occasionally ☐ seldom ☐ never

My occupation is ☐ homemaker ☐ unemployed ☐ disabled ☐ ________________

Please check if anyone in your family has any of the following problems:

___ High blood pressure
___ Heart attack/problem
___ Stroke
___ Asthma
___ Emphysema
___ Diabetes
___ High cholesterol
___ Seizures
___ Cancer of any kind

Please check if any of the following symptoms have recently troubled you:

General
___ fevers or sweats
___ undesired weight loss

Eyes
___ vision worsening
___ double vision

Ear, Nose, Throat
___ hearing loss
___ difficulty swallowing

Cardiovascular
___ chest pain
___ chest heaviness

Respiratory
___ short of breath
___ coughing blood

Gastrointestinal
___ blood in stool
___ vomiting blood

Genitourinary
___ blood in urine
___ discharge

Musculoskeletal
___ joint swelling
___ muscle weakness

Skin
___ black moles
___ changing moles

Neurological
___ convulsions
___ falling

Psychiatric
___ lack of pleasure and fun
___ thoughts of suicide

Endocrine
___ hot flashes
___ can't tolerate cold temperatures

Hematology
___ bruising easily
___ bleeding frequently

Allergy
___ wheezing
___ nasal congestion

Sexual
___ sex life could be better

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HEALTH MAINTENANCE:

ITEM	DATE (approximate)	PHYSICIAN AND/OR RESULT
Osteoporosis scan		
Mammogram		
Tetanus shot		
Pneumonia shot		
Lab work		
Colonoscopy		

Current Contraception: □ Pill □ Tubal Ligation □ Condoms □ Other: ___________________
Number of Vaginal Deliveries: _____ C/Sections: _____ Miscarriages: _____ Abortions: _____

Current and past Physicians and Healthcare Providers you want us to contact: _________

____

____

____

INSTRUCTIONS: This questionnaire will help in understanding problems that you may have. It may be necessary to ask you more questions about some of these items. Please make sure to check a box for every item.

During the PAST MONTH, have you been bothered A LOT by…	Yes	No		Yes	No	In the past month…	Yes	No
1. Stomach Pain	□	□	12. Constipation, loose bowels or diarrhea	□	□	21. Have you had an anxiety attack (suddenly feeling fear or panic)	□	□
2. Back Pain	□	□	13. Nausea, gas or indigestion	□	□	22. Have you thought you should cut down on your drinking alcohol	□	□
3. Pain in your arms, legs, or joints (knees, hips, etc.)	□	□	14. Feeling tired or having low energy	□	□	23. Has anyone complained about your drinking alcohol	□	□
4. Menstrual pain or problems	□	□	15. Trouble sleeping	□	□	24. Have you felt guilty or upset about your drinking alcohol	□	□
5. Pains or problems during sexual intercourse	□	□	16. Your eating being out of control	□	□	25. Have you had five or more drinks of alcohol in a single day	□	□
6. Headaches	□	□	17. Little interest or pleasure in doing things	□	□	Overall, you'd say your health is:		
7. Chest pain	□	□	18. Feeling down, depressed or hopeless	□	□	Excellent	□	
8. Dizziness	□	□	19. "Nerves" or feeling anxious or on edge	□	□	Very Good	□	
9. Fainting spells	□	□	20. Worrying about a lot of different things	□	□	Good	□	
10. Feeling you heart pound or race	□	□				Fair	□	
11. Shortness of breath	□	□				Poor	□	