Elizabeth A. Triana, M.D.

3155 Harbor Blvd, Suite 100 Family Practice (941)625-1990
Port Charlotte, FL 33952 Fax (941)625-1991

Patient Name: ______________________ Account No.: __________________ DOB: ___/___/____

Initial Visit Form (p.1): Please Provide the following medical information to the best of your ability:

Date : __________________________ Age: ____________________ List All Allergies to Medications:

What Problems are you here for today?

Past Medical History: 1.) Please check the "Yes" or "No" box to indicate if you have any of the following illnesses: for "Yes" answers, please explain.

	Yes	No			Yes	No	
Diabetes (Circle: type I / type II)	□	□	______	**Stomach or Intestinal Probs**	□	□	______
Hypertension (high blood press)	□	□	_______	**Allergy Problems/Therapy**	□	□	______
Thyroid Problems	□	□	________	**Kidney Problems**	□	□	______
Heart Disease/Cholesterol Probs	□	□	_________	**Neurological Problems**	□	□	______
Respiratory Problems	□	□	_________	**Cancer**	□	□	______
Bleeding Disorder	□	□	_________	**Other Medical Diagnosis**	□	□	______

2.) Please list any operations (and dates) you have ever had (*including tonsils and adenoids*)

3.) Please list current medications (and amounts, times per day) :

(include aspirin, antacids, vitamins, hormone replacement, birth control, herbal supplements, OTC meds including sinus/allergy/weight loss meds)

Social History:	Yes	No	**Please List Details Below**
Do you se tobacco?	□	□	**List Type and How Much:** ______________
If no, did you use it previously?	□	□	**List Type and How Much:** _________ **When did you quit?**
Do you drink alcohol?	□	□	**List Type and How Much:** ______________
Do you use recreational drugs?	□	□	**List Type and How Much:** ______________

What is your occupation?

Family History:

Please check the "Yes" or "No" box to indicate whether any relatives have any of the following illnesses: If yes, please indicate which relative(s) have the problem.

	Yes	No	
Heart problems/murmurs	□	□	______________________
Allergy	□	□	______________________
Diabetes	□	□	______________________
Cancer	□	□	______________________
Bleeding disorder	□	□	______________________
Anesthesia problems	□	□	______________________

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Patient Name: ____________________ Account No.: ________________ DOB: ___/___/____

Outpatient Initial Visit Form (p. 2): Please provide the following medical information to the best of your ability:

Review of Systems:

1.) **Please check the "Yes" or "No" box to indicate whether you presently have any of the following symptoms**
2.) **For any "Yes" responses, please check the "Current" box if this symptom relates to the reason for your visit today.**

		Yes	No	Current		Yes	No	Current
General	**Chills**	□	□	□	**Weight Loss or Gain**	□	□	□
	Fatigue	□	□	□	**Daytime Sleepiness**	□	□	□
Allergy	**Environmental Allergy**	□	□	□	**Sneezing Fits**	□	□	□
Neuro	**Headache**	□	□	□	**Weakness**	□	□	□
	Passing Out	□	□	□	**Numbness, Tingling**	□	□	□
Eyes	**Eye Pain/Pressure**	□	□	□	**Vision Changes**	□	□	□
	Watery or Itchy Eyes	□	□	□				
ENT	**Hearing Loss**	□	□	□	**Ear Noises**	□	□	□
	Dizziness	□	□	□	**Lightheadedness**	□	□	□
	Nasal Congestion	□	□	□	**Sinus Pressure or Pain**	□	□	□
	Hoarseness	□	□	□	**Problem Snoring, Apnea**	□	□	□
	Throat Clearing	□	□	□	**Throat Pain**	□	□	□
Respi	**Cough**	□	□	□	**Coughing Blood**	□	□	□
	Wheezing	□	□	□	**Shortness of Breath**	□	□	□
Cardiac	**Chest Pain**	□	□	□	**Palpitations**	□	□	□
	Wake Short of Breath	□	□	□	**Ankle Swelling**	□	□	□
GI	**Difficulty Swallowing**	□	□	□	**Heartburn**	□	□	□
	Abdominal Pain	□	□	□	**Nausea/Vomiting**	□	□	□
	Bowel Irregularity	□	□	□	**Rectal Bleeding**	□	□	□
GU	**Frequent Urination**	□	□	□	**Painful Urination**	□	□	□
	Blood in Urine	□	□	□	**Prostate Problems**	□	□	□
Heme/Lym	**Swollen Glands**	□	□	□	**Sweating at Night**	□	□	□
	Bleeding Problems	□	□	□	**Easy Bruising**	□	□	□
Endo	**Feel Warmer than Others**	□	□	□	**Feel Cooler than Others**	□	□	□
MSK	**Joint Aches**	□	□	□	**Muscle Aches**	□	□	□
SKIN	**Rash**	□	□	□	**Hives**	□	□	□
	Itching	□	□	□	**Skin or Hair Changes**	□	□	□
PSYCH	**Depression**	□	□	□	**Anxiety or Panic**	□	□	□

________________**Please Stop Here**________________

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Patient Name: ______________________ **D.O.B**______________________

Social History

Marital Status: Married / Single / Widowed / Divorced / Engaged / Significant Other

Do you have any biological children? If so, please specify age and gender of each:

____

____

Who do you live with?

____

Do you have any pets? If so, please specify:

____

What is your occupation?

____

Nutritional Status: Poor/ Fair/ Good/Excellent/ Vegetarian

Do you Exercise? If so, please specify type and duration:

____

____

Sexual Activity: Not sexually active/ Monogamist/ Multiple Partners

Contraceptive Use: None/ Oral Contraceptive/ Family Planning/ Condoms/ Intrauterine Device/ Hysterectomy/ Vasectomy/ Abstinence

Smoking Status: If so, please include history, duration and amount per day:

____

____

Alcohol Status: If so, please include history, duration and amount per day:

____

____

Do you use illicit drugs?

____

Do you wear your seatbelt? ____

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Past Medical History

Please list any diseases or health related problems that you have (including but not limited to high blood pressure, high cholesterol, coronary artery disease, strokes, kidney disease, anxiety, depression, osteoporosis, arthritis, or any other disease processes.)

____

____

____

____

____

____

Surgeries or Medical Procedures

Please list any surgeries or medical procedures that you have had in the past and the approximate year of the procedure.

____

____

____

____

____

____

Additional Information (Women Only)

How many times have you been pregnant? ___________________________________

How many children do you have? ____

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Family History (Please Circle One)

Mother: Deceased or Alive

History Of:
Alzheimer's
Arthritis
Asthma
Cancer: Please specify type: ___________________________________
Coronary Artery Disease
High Cholesterol
Alcohol Abuse
Diabetes: Please specify type: ___________________________________
Depression
Hypertension
Obesity
Osteoporosis
Kidney Disease
Stroke
Thyroid Disorder: Please specify: _______________________________

Father: Deceased or Alive

History Of :
Alzheimer's
Arthritis
Asthma
Cancer: Please specify type: ___________________________________
Coronary Artery Disease
High Cholesterol
Alcohol Abuse
Diabetes: Please specify type: ___________________________________
Depression
Hypertension
Obesity
Osteoporosis
Kidney Disease
Stroke
Thyroid Disorder: Please specify: _______________________________

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Siblings: Brothers: 1, 2, 3, 4 or _____ Sisters: 1, 2, 3, 4 or _____

Deceased or Alive

Please comment on each of your sibling's medical history below.

____

____

____

____

____

____

Extended Family History:

Cancer: Please specify type: ________________________________
Coronary Artery Disease
High Cholesterol
Alcohol Abuse
Diabetes: Please specify type: _______________________________
Hypertension
Depression
Kidney Disease
Stroke