

# SURGICAL SPECIALISTS



## 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: \_\_\_\_\_

Other important hospitalizations and illnesses: \_\_\_\_\_

Do you live  alone  with family  with friends  in group home

Do you smoke  none  \_\_\_\_ packs per day  \_\_\_\_ cigarettes per day  
 quit smoking (year) \_\_\_\_\_  \_\_\_\_ cigars or pipe only

Do you use alcohol  every day  every week  occasionally  seldom  none

Your occupation is  homemaker  unemployed  disabled  \_\_\_\_\_

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

\_\_\_ High blood pressure      \_\_\_ Asthma      \_\_\_ High cholesterol  
\_\_\_ Heart attack/heart problem      \_\_\_ Emphysema      \_\_\_ Seizures  
\_\_\_ Stroke      \_\_\_ Diabetes      \_\_\_ 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

**HEALTH MAINTENANCE:**

| ITEM           | DATE<br>(approximate) | PHYSICIAN AND/OR RESULT |
|----------------|-----------------------|-------------------------|
| Pap            |                       |                         |
| Mammogram      |                       |                         |
| Tetanus shot   |                       |                         |
| Pneumonia shot |                       |                         |
| Cholesterol    |                       |                         |
| Sigmoidoscopy  |                       |                         |

Current Contraception:  Pill  Tubal Ligation  Condoms  Other: \_\_\_\_\_

Number of Vaginal Deliveries: \_\_\_\_\_ C/Sections: \_\_\_\_\_ Miscarriages: \_\_\_\_\_ Abortions: \_\_\_\_\_

**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.

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