



Dr. Craig Amshel

Insurance _____

1046 Cypress Village Blvd, Sun City Center Blvd, FL 33573 813-633-0081

PCP: _____ Date: _____

Patient: _____ Age: _____

DOB: _____ Height: _____ Weight: _____ Pharmacy: _____

Reason for Visit: _____ BP _____ P _____ Notes:

MEDICATIONS:

- 1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Empty rounded rectangular box for notes.

Are you allergic to any medications? Yes ___ No ___ If so what _____ Reaction: _____

PAST MEDICAL HISTORY

- Diabetes T1 T2, High Blood Pressure, Heart disease, Heart Attack, Asthma, Bronchitis/emphysema, Pneumonia, Hard of Hearing, Hypo/Hyper Thyroid, Arthritis, History of Cancer, Blood Clots, High Cholesterol, Crohn's Disease, IBS, GERD, Colon Polyps, Diverticulitis / osis, BPH, Depression / Anxiety

PAST SURGICAL HISTORY

- Appendectomy, Breast Surgery R/L, Hernia R/L, Gallbladder, Back Surgery, Hysterectomy, Heart Bypass, Prostate, Tubal ligation, Vasectomy, Never had a colonoscopy, Colonoscopy date, EGD date, Knee scope R/L, Other: _____

Family Medical History

- Family Colon Cancer ___Y___N Who? _____
Family Heart Disease Yes ___ No ___
Family Adverse reaction to anesthesia Y ___ N ___
Family medical illness _____ Mother A D _____ Father A D _____ Siblings _____

Social History

- Marital Status M D S W
Smoke Y ___ N ___ Packs ___ How Long ___
Alcohol Y ___ N ___ Sometimes ___ How Much ___

HISTORY OF PRESENT ILLNESS

- Cardiovascular: Chest pain Y N, Irregular HB Y N, Stroke Y N
Musculoskeletal: Joint pain Y N, Back pain Y N, Neck pain Y N
Neurological: Tremors Y N, Numbness Y N, Headache Y N
Hematologic: Swollen glands Y N, Blood clots/bleeding issues Y N, Anemia Y N
Integumentary: Skin Rash Y N, Boils Y N, Itch Y N, Psoriasis Y N
Respiratory: SOB Y N, wheezing Y N, Cough Y N, Asthma Y N
Psychologic: History of depression Y N, Hx of Biopolar disorder Y N, Sleeping Problems Y N
Urology: Incontinence Y N, Retention Y N, Nocturia Y N, Hematuria Y N
Gastroenterology: Abdominal pain Y N, Constipation Y N, Diarrhea Y N, Difficulty Swallowing Y N, Fecal Incontinence Y N, How many / often accidents ____, Rectal Bleeding Y N, Nausea Y N

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