Joseph G. Spano, M.D., P.A.

DIPLOMATE AMERICAN BOARD OF INTERNAL MEDICINE
CONCIERGE
INTERNAL MEDICINE * GASTROENTEROLOGY
130 Tamiami Trail North #130
Naples, Florida 34102
(239) 263-4470
(239) 403-1655

MEDICAL HISTORY QUESTIONNAIRE

Please read carefully and complete prior to your appointment.

Date: _____

Name: _____ Age: _____ Birthdate: _____

This is a confidential questionnaire. Please answer each question as completely as possible. This information will help your physician and nurses to provide you with the best possible care.

1. List any problems that are a major concern to you.

_____
_____
_____
_____

PAST MEDICAL HISTORY

1. Are you taking or recently have you been taking any medications? YES ____ NO ___

(Include aspirin, sleeping pills, birth control pills, vitamins and hormones)

NAME OF MEDICATION	AMOUNT PER DAY	WHEN STARTED

2. Do you have an allergy to or have you had a serious reaction to any medication, Anesthetic or compound used internally or on skin, etc.?

NAME OF MEDICATION	TYPE OF REACTION

3. If you previously have been a patient in a hospital or had any surgery, list below all admissions. Use back if needed. (Don't forget appendectomy or tonsillectomy).

YEAR	REASON	PLACE

4. In the past have you had any other surgery, serious illness, injury or disability? (Even if outside the hospital). If YES, describe below.

YEAR	MEDICAL PROBLEM

5. Have you ever had:

SCARLET FEVER	YES __NO__	BLEEDING TENDENCIES	YES__NO__
RHEUMATIC FEVER	YES __NO__	CANCER OR TUMOR	YES__NO__
POLIOMYELITIS	YES __NO__	KIDNEY TROUBLE	YES__NO__
HEPATITIS	YES __NO__	HIGH BLOOD PRESSURE	YES__NO__
MALARIA	YES__NO__	HEART TROUBLE	YES__NO__
MUMPS	YES__NO__	DIABETES	YES__NO__
MEASLES	YES__NO__	THYROID TROUBLE	YES__NO__
GERMAN MEASLES	YES__NO__	PEPTIC ULCER	YES__NO__
VENEREAL DISEASE	YES__NO__	DIVERTICULITIS	YES__NO__
ASTHMA	YES__NO__	PARASITES	YES__NO__
BRONCHITIS	YES__NO__	PNEUMONIA	YES__NO__

6. When did you last have? Immunization against?

	YEAR		YEAR
Chest X-ray		Small Pox	
Electrocardiogram		Tetanus	
Blood Count		Polio	
Blood Chemistries		Typhoid	
Blood Transfusion		Flu	
Medical Check up		Mumps	
Upper GI series		Measles	
Barium Enema		German Measles	
Gallbladder X-ray		Other	
Colonoscopy		Upper Endoscopy	

a. Do you have trouble sleeping? YES ___ NO ___

b. Do you smoke or have you been a smoker? YES ___ NO ___
If YES, describe the type, amount and duration of habit.

_____

_____

c. Do you now or have you in the past, customarily taken two or more alcoholic drinks per day? YES ___NO ___

d. Has drinking ever been a problem for you? YES ___NO ___

e. Have you ever been addicted to drugs or alcohol? YES ___NO ___

f. Have you ever used marijuana, LSD, heroin or similar drugs? YES___ NO___

g. Are you on a special diet or do you restrict your diet in any way? YES___ NO___
If YES, please explain below.

_____

_____

h. How many cups of coffee or tea per day? #_____

i. Do you exercise daily? YES ___NO ___
If YES, what kind? _____

_____

j. Have you had unusual weight gain or loss in the past year? YES___NO___
If YES, please describe. _____

_____

k. Have you been subjected to any unusual stresses or been exposed to dangerous or toxic material in your home or work? YES ___NO___

l. Pets? YES ___NO___

m. Are you now or have you in the past received disability benefits from any government agency, employer or insurance company? YES ___NO___

n. How many days of work did you miss due to illness or injury in the past 12 months?
(Closest estimate) _____days.
Give reasons for loss of work (type of illness or injury) _____

_____

Where were you born? _____

In what countries have you lived in? _____

What countries have you visited in the past (5) years? _____

_____

Describe years and places of any military service and type of discharge. _____

_____

_____

Any illness in service? _____

Give your age(s) at time of marriage(s) _____

Are you employed? YES ____ NO ____

If yes, what is your present job and how long have you had it? _____

If retired, what were your previous jobs? _____

_____

Do you have an updated living will? YES ____ NO____

Do you have a Medical Surrogate? YES ____NO____

Does someone have Power of Attorney on your behalf? YES____NO____

7. List any special medical problems you would want to discuss with the doctor on the day of the examination. _____

_____

_____

_____

	AGE AT DEATH	ALIVE	SIGNIFICANT HEALTH PROBLEMS OR CAUSE OF DEATH
FATHER			
MOTHER			
BROTHERS/SISTERS			
M/F			
M/F			
M/F			
CHILDREN			
M/F			
M/F			
M/F			
GRANDPARENTS (MOTHER'S SIDE)			
MALE			
FEMALE			
GRANDPARENTS (FATHER'S SIDE)			
MALE			
FEMALE			

*Since some names may be used for either men or women, please circle sex for each Brother, Sister, Son or Daughter.

Do you know of any blood relative who had: (check "yes" and give relationship)

	YES	RELATIONSHIP		YES	RELATIONSHIP
Stroke			Congenital Heart		
Cancer			Heart Attack		
Migraine			Stomach Ulcer		
Arthritis			Kidney Disease		
Nervous Breakdown			High Blood Pressure		
Bleeding Tendencies			Insanity		
Epilepsy			Leukemia		
Suicide			Asthma		
Hay Fever			Goiter		
Colitis			Diabetes		
Tuberculosis					

Over the past 2 weeks, how often have you been bothered by any of the following problems?

	NOT AT ALL	SEVERAL DAYS	MORE THAN HALF DAYS	NEARLY EVERY DAY

Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed or hopeless	0	1	2.	3

REVIEW OF SYSTEMS:

8. Have you ever had any of the following in a serious or chronic way? If YES, circle the number.

a. **EYE PROBLEMS**
1. Double Vision
2. Blurring of vision
3. Puffy eyelids
4. Injury of eyes
5. Infection of eyes
6. Painful eyes
7. Colored rings around light
8. Temporary loss of vision
9. Glaucoma
10. Macular Degeneration

b. **EAR TROUBLES**
1. Pain in ears
2. Discharge from ears
3. Loss of hearing
4. Ringing in ears
5. Mastoid trouble
6. Other

c. **NOSE, THROAT OR MOUTH DISORDERS**
1. Nasal stuffiness or discharge without a cold
2. Frequent sneezing spells
3. Frequent or severe nose bleeds
4. Prolonged or recurring sore throat
5. Prolonged or recurring sinus pain
6. Recurring hoarseness
7. Sore mouth or tongue
8. Mouth ulcers
9. Severe teeth or gum pain
10. Other

d. **BREAST PROBLEMS**
1. Lumps in breasts
2. Soreness of breasts
3. Discharge from breasts
4. Others _____
5. Last mammogram – When? Where? _____

e. HEART, LUNGS OR CIRCULATORY PROBLEMS
If YES, please circle the number.

1. Heart murmur
2. High blood pressure
3. Rapid or irregular heart beat
4. Shortness of breath with little effort
5. Shortness of breath when lying flat
6. Heart attack
7. Pains or tightness in chest with exertion or excitement
8. Swelling of foot or ankles
9. Recurrent or persistent cough
10. Coughing up blood
11. Wheezing or noisy breathing
12. Chest pains with deep breath
13. Soaking sweats at nighttime
14. Cramps in legs when walking
15. Varicose vein trouble
16. Phlebitis production
17. Leg cramps at night
18. Other _____

f. DIGESTIVE, STOMACH OR INTESTINAL DIFFICULTIES

1. Difficult or painful swallowing
2. Poor appetite
3. Nausea or vomiting
4. Heartburn or discomfort in pit of stomach
5. Pain or soreness in abdomen
6. Unusual swelling or bloating in abdomen
7. Unusual burping or passing of gas
8. Loose bowel movements for more than one day
9. Gray bowel movement
10. Black or bloody movements
11. Unusual constipation
12. Painful bowel movements
13. Bleeding from rectum
14. Soreness or pain from the rectal area
15. Jaundice (yellow skin/eyes)
16. Recent change in bowel habits
17. Foul odor to stools

18. Change in weight in past year
19. Other _____

g. URINARY OR GENITAL PROBLEMS
If YES, please circle the number.

1. Pains or burning with urination
2. How many times do you urinate during the night? _____
3. How many times do you urinate during the day? _____
4. Trouble holding water
5. Difficulty starting urination
6. Brown or bloody urine
7. Pus or albumin in the urine
8. Kidney stones or colic
9. Sores on genitals
10. Others _____

h. BONES AND JOINT PROBLEMS

1. Painful joints and back
2. Swollen joints
3. Early morning stiffness
4. Stiffness of joints
5. Other _____

i. MUSCULAR, BRAIN OR NERVE DISORDERS

1. Serious head injury
2. Frequent or severe headache
3. Fainting spells
4. Seizures or epilepsy
5. Dizziness or trouble with balance
6. Twitching, trembling or shaking
7. Unusual loss of coordination or strength
8. Tingling or numbness in any part of the body
9. Loss of sense of smell, taste, etc
10. Other _____

j. BLOOD DISORDERS OR BLEEDING PROBLEMS

1. Anemia or abnormal blood count
2. Tendency to bruise easily
3. Enlargement of Lymph glands

4. Trouble stopping bleeding from even small cuts
5. Other _____

k. THYROID OR GLANDULAR PROBLEMS
If YES, please circle number.

1. Goiter (enlarged thyroid gland)
2. Unusual sensitivity to heat or cold
3. Bulging or prominence of eyes
4. Unusual thirst or urinating
5. Changes in appetite
6. Tired or exhausted most of the time
7. Frequent boils or skin infection
8. Unusual growth or loss of hair

TO BE COMPLETED BY *MEN ONLY*

1. Weak or slow stream
2. Prostate trouble _____
3. Discharge from penis
4. Pains or swelling of testes
5. Difficulty with erection or intercourse

TO BE COMPLETED BY *WOMEN ONLY*

1. Excessive vaginal discharge
2. Pain or difficulty with intercourse
3. Have your menstrual periods stopped? YES _____ NO _____
4. Heavy bleeding with periods
5. Irregular or abnormal periods
6. Loss of urine with cough
7. Hysterectomy? Partial _____ Total _____
8. Endometriosis

When was your last pap test? _____
When was your last period? _____
Number of pregnancies? _____
Number of stillbirths, miscarriages or abortions? _____
Number of cesarean sections? _____
Number of children born alive? _____

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns	+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

TOTAL:

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	_____
	Somewhat difficult	_____
	Very difficult	_____
	Extremely difficult	_____

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130 TAMIAMI TRAIL NORTH
SUITE 130
NAPLES, FLORIDA 34102-8233
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ADVANCE DIRECTIVES CHECKLIST

A. _____ Patient and/or his/her family, surrogate or other concerned person was provided with written information regarding their rights under Florida law to accept or refuse treatment and execute advance directives and UM's policy concerning implementation of these rights.

B. The patient or the patient's representative indicated (check as applicable)

_____ 1. Patient has an advance directive and provided a copy of it upon admission

_____ 2. Patient has an advance directive, but does not have it with him/her

- Location/Content of advance directive
- I direct my attending physician to withhold or withdraw life sustaining treatment that serves only to prolong the process of my dying, if I should be in a terminal condition or in a state of permanent unconsciousness,
- I direct that treatment be limited to measures to keep me comfortable and to relieve pain, including any pain that might occur by withholding or with drawing life-sustaining treatment,
- I direct that treatment be limited to measures to keep me comfortable and to relieve pain, including any pain that might occur by withholding or withdrawing life-sustaining treatment.

In addition, if I am in the condition described above:

I do ____ do not ____ want cardiac resuscitation.

I do ____ do not ____ want mechanical respiration.

I do ____ do not ____ want tube feeding or any other artificial or invasive form of nutrition (food) or hydration (water)

I do ____ do not ____ want blood or blood products.

I do ____ do not ____ want any form of surgery or invasive diagnostic tests.

I do ____ do not ____ want kidney dialysis

I do ____ do not ____ want antibiotics

Health Care Surrogate Name: _____

Address: _____

Phone number: _____

_____ 3. Patient has decision-making capacity and does not have an advance directive

_____ 4. Patient is unable to communicate and is unaccompanied, without advance directives

_____ 5. Patient is unable to communicate and his/her representative does not know if patient has an advance directive.

Patient Signature: _____ Date/Time: _____

If patient is unable to sign:

Representative's Signature: _____ Relationship: _____ Date/Time: _____