

PATIENT GENERAL INFORMATION

NOTE: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.

NAME _____
 OCCUPATION _____
 Date of last physical examination _____
 Was it Normal No ___ Yes ___
 Abnormal Finding: _____

MARRIED ___ WIDOW (ER) ___
 SINGLE ___ DIVORCED ___
 DATE OF BIRTH: _____
 RACE: _____
 ETHNICITY: _____
 PREFERRED LANGUAGE: _____

FAMILY HISTORY

PLEASE CIRCLE

Cancer	NO	YES
Tuberculosis	NO	YES
Diabetes	NO	YES
Heart Trouble	NO	YES
Anxiety	NO	YES
High Blood Pressure	NO	YES
Stroke	NO	YES
Epilepsy	NO	YES
Depression	NO	YES
Ulcers	NO	YES
Other Diseases	NO	YES

FAMILY MEMBERS

WHO _____	KIND _____
WHO _____	KIND _____
WHO _____	KIND _____
WHO _____	
WHO _____	INSULIN _____ PILL _____
WHO _____	INSULIN _____ PILL _____
WHO _____	INSULIN _____ PILL _____
WHO _____	KIND _____
WHO _____	KIND _____
WHO _____	
WHO _____	
WHO _____	
WHO _____	KIND _____
WHO _____	WHAT _____
WHO _____	WHAT _____

PERSONAL HEALTH HISTORY

Rheumatic Fever	NO	YES
Bone or Joint Disease	NO	YES
Sexually Transmitted Disease	NO	YES
Gallbladder Disease	NO	YES
Anemia	NO	YES
Hay Fever or Asthma	NO	YES
Bladder Disease	NO	YES
Migraine Headaches	NO	YES
Diabetes	NO	YES
High Blood Pressure	NO	YES
Colitis or Bowel Disease	NO	YES
Depression or Anxiety	NO	YES
Cancer	NO	YES
Ulcer Disease	NO	YES
Other Disease	NO	YES

WHEN _____
SPECIFY _____
WHEN _____
WHEN _____
WHEN _____ KIND _____
HOW LONG _____
SPECIFY _____
HOW OFTEN _____
INSULIN _____ PILL _____
UNDER TREATMENT NOW- NO YES
UNDER TREATMENT NOW- NO YES
UNDER TREATMENT NOW- NO YES
WHO _____ KIND _____
WHO _____ KIND _____
WHO _____ KIND _____
WHO _____ KIND _____

PLEASE PROVIDE S.A.M.C. WITH COPIES OF ANY ADVANCED DIRECTIVE SUCH AS MEDICAL POWER OF ATTORNEY, DNR, ETC.

LIST ANY SURGERIES AND DATE PERFORMED: _____

LIST HOSPITALIZATION FOR ANY ILLNESS OTHER THAN SURGERY: _____

HISTORY OF INJURIES:

Broken Bones	NO	YES	SPECIFY _____
Dislocations	NO	YES	SPECIFY _____
Concussion, or Head Injury	NO	YES	SPECIFY _____

LIST ANY DRUG ALLERGIES

LIST ALL LONGTERM PRESCRIPTION MEDICATION YOU:
ARE CURRENTLY TAKING

HAVE TAKEN IN THE PAST

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

DO YOU SMOKE?	NO	YES	CIG. PER DAY _____
DO YOU DRINK ALCOHOL?	NO	YES	DRINKS PER WEEK _____
DO YOU DRINK CAFFEINATED DRINS (INCLUDING COFFEE, TEA, & COLA)	NO	YES	CUPS PER DAY _____

HAVE YOU EVER HAD BLOOD OR PLASMA TRANSFUSION?

DATE OF LAST DIPHTHERIA-TETANUS BOOSTER _____

WOMEN:

Date of last menstrual period _____

Do you take Birth Control Pills? No Yes

Date and result of last Pap Smear Date _____ Result _____

LIST PREVIOUS DOCTORS IN AUSTIN WHO HAVE TREATED YOU:

