Name: Date:

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Office: 832 964 4001 Fax: 832 403 2582

Patient Medical History Date:

Last Name:	First Name:	Middle Initials:	Suffix:	DOB: / /

Chief complaint: what is the reason for your visit today?

Past Medical History:

		Yes	No	Comments
General	Fever	-	-	
	Chills	-	-	
	Weight loss	-	-	
Ear, Nose & Throat	Change of vision	-	-	
	Nose bleed	-	-	
	Ear discharge	-	-	
	Hearing loss	-	-	
Neurology	Headache	-	-	
	Dizziness	-	-	
	Transient Ischemic Attacks	-	-	
	Stroke	-	-	
	Numbness	-	-	
	Muscle weakness	-	-	
CVS	Chest pain	-	-	
	Palpitation	-	-	
	Hypertension	-	-	
Pulmonology	Cough	-	-	
	Difficulty breathing	-	-	
	Asthma	-	-	
	Difficulty lying flat	-	-	
GI	Poor appetite	-	-	
	Abdominal pain	-	-	
	Hepatitis	-	-	
	Jaundice	-	-	
	Constipation	-	-	
	Diarrhea	-	-	
	Bloody stools	-	-	
Urology	Frequency	-	-	

Name: Date:

	Pain on urinating Bloody urine	- -	- -	
Endocrine	Diabetes Mellitus Hypothyroidism Hyperthyroidism Hyperparathyroidism	- - - -	- - - -	
Hematology	Bleeding tendency DVT (blood clots) Malignancy Blood transfusion	- - - -	- - - -	 If Yes when?
Musculoskeletal	Back Pain Joint pain Joint swelling	- - -	- - -	
Dermatology	Rash Skin Lesions	- -	- -	
Autoimmune disorder		-	-	
Psychiatry	Depression Sleeping disorder Anxiety disorder Bipolar disorder	- - - -	- - - -	
Other				

Past Surgical History: Please list any surgical procedures you had

Type of Surgery	**Date**	**Hospital**

Allergies: Please, list any drug allergies you may have including intravenous dyes used in radiology

Medication Name	**Reaction**

Name: Date:

Medications: Please, list all your current medications.

Name	Dose (mg, microg, mls…ect)	Frequency

Social History:

Occupation:

Marital Status: -Single -Married -Divorces -Separated -Widowed

Do you have children?	o Yes	o No	How many?
Do you use tobacco?	o Yes	o No	How many/day……. For how long……. If quit, when…….
Do you Drink Alcohol?	o Yes	o No	How often?.....
Do you use illicit drugs	o Yes	o No	What kind? How often?
Recent travel abroad	o Yes	o No	If yes where and when?

Family History: Please, list any disease you know of in your immediate family

Relation	Disease

Signature Date: