

Emad H. Asham, M.D., F.R.C.S.
Adjunct Associate Professor of Surgery, Texas A&M School of Medicine
 Minimally Invasive, Oncological & General Surgeon
 6560 Fannin Street, Scurlock Tower, Suite 1630, Houston, TX 77030
 Office Phone: 832 964 4001 Office Fax: 346 299 9071

Patient Medical History

Last Name:	First Name:	Middle Initials:	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	-	-	
	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

Medications: Please, list all your current medications.

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

Social History:

Occupation:

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

Do you have children?	<input type="radio"/> Yes	<input type="radio"/> No	How many?
Do you use tobacco?	<input type="radio"/> Yes	<input type="radio"/> No	How many/day..... For how long..... If quit, when.....
Do you Drink Alcohol?	<input type="radio"/> Yes	<input type="radio"/> No	How often?.....
Do you use illicit drugs	<input type="radio"/> Yes	<input type="radio"/> No	What kind? How often?
Recent travel abroad	<input type="radio"/> Yes	<input type="radio"/> No	If yes where and when?

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

Relation	Disease

Signature:

Date: