Texas Health Physicians Group

Patient History

Name:____**DOB:**______________________________

REASON FOR TODAYS VISIT:____

Have you been treated for this before?________Yes_________No

If so, please give details:____

ALLERGIES *List all known allergies and reactions*: ____

____

MEDICATIONS

List all current medications, prescription and nonprescription (EXAMPLE: ASPIRIN, HERBALS, VITAMINS):

Medication	Dose	Frequency	Start Date

MEN ONLY:

	YES	*Date*		*YES*	*Date*		*YES*	*Date*
Prostate Problems			Prostate Cancer			Cancer of the Testicles		

WOMEN ONLY:

Abnormal Pap Smear			Cervical Cancer			Ovarian Cancer		

Pregnancies:	Deliveries:	Miscarriages:	Abortions:
Method of Birth Control if Applicable:	**Date of Last Menstrual Period:**	Could you be pregnant?____Yes_____No	

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HEALTH MANAGEMENT:

Please indicate when you last had each of the following exams and if the results were normal /abnormal:

	Date	Normal	Abnormal		Date	Normal	Abnormal
Dental				Bone Density Test/DEXA			
Ophthalmology				Mammogram (female)			
Stress Test				Pelvic/Pap Smear (female)			
Colonoscopy (over age 50)				Breast exam (female)			
Stool test for blood				PSA Exam (male)			
Chest X-ray				Rectal/Prostate Exam (male)			
Tuberculosis skin test (PPD)				Tetanus Shot			
Pneumonia Shot				Flu Shot			
Hepatitis A & B				Shingles Shot			
Gardasil Shot(s) (female)				Other: _________________			

MEDICAL HISTORY (*Check all that apply***)**

	YES	***Date***		***YES***	***Date***		***YES***	***Date***
Hypertension (High Blood Pressure)			TB (Tuberculosis)			Other Arthritis		
Stroke			Pneumonia			Gout		
Seizures			Emphysema (COPD) or Chronic Bronchitis			Osteoporosis/osteopenia		
Migraines			Heart Abnormalities			Skin disease		
Anemia			Congestive Heart Failure			Phlebitis/blood clots		
Lung cancer			Myocardial Infarction (Heart Attack)			Anemia		
Breast cancer			Mitral Valve Disease			Bleeding disorder		
Colon cancer			High Cholesterol			Depression		
Skin cancer			Coronary Artery Disease			Anxiety		
Other cancer: __________			Psychiatric			Chicken Pox		
Hyperthyroid			Heart Murmur			Measles		
Hypothyroid			Heart Valve Disease			Mumps		
Diabetes			Heart Palpitations or arrhythmias			Infectious Mono		
Stomach or Peptic Ulcer			Pulmonary fibrosis			Allergies/Hay fever		
Kidney Disease			Any other lung disease not mentioned			Hives or Eczema		
Sleep Apnea			Hiatal hernia/GERD			Blood Transfusion		
Liver Disease			Gallstones			Bladder Infections		
Hepatitis			Pancreatitis			Hemorrhoids		
AIDS/HIV			Colitis (not spastic colon)			Hernia		
Sexually Transmitted Disease			Spastic colon or irritable bowel			Back Problems		
			Kidney stones			Other: ______________		
Cataract			Kidney infections			Other: ______________		
Glaucoma			Rheumatoid arthritis			Other: ______________		
Asthma			Osteoarthritis			Other: ______________		

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Concussion	YES	Date	Broken Bones/Fractures	YES	Date

SURGICAL HISTORY

	YES	Date		Date
Cholecystectomy (Gallbladder)			Other:____________	
Appendectomy			Other:____________	
Tonsillectomy				
Hysterectomy				

FAMILY HISTORY

Please indicate in the spaces below any family members with a history of: diabetes, heart disease, cancer, emphysema, kidney disease, asthma, bleeding tendencies, anemia, epilepsy, glaucoma, high blood pressure, gout, arthritis, ulcer, stroke, nervous breakdown, gall bladder disease. .

Family Member	Age if Living	Health Problems	Age at Time of Death	Cause
Father				
Paternal Grandfather				
Paternal Grandmother				
Mother				
Maternal Grandfather				
Maternal Grandmother				
Brothers (How many in all?_____)				
Sisters (How many in all?_____)				
Sons (How many in all?_____)				
Daughters (How many in all?____)				
Other family members				

SOCIAL HISTORY

Your Personal Habits: Do you?	YES	NO	Date Quit	If Yes, how much/how often?
Smoke				
Drink Alcohol				
Use recreational/Intravenous street drugs				

Do you exercise on a regular basis? Yes☐ No☐
If so, how much and how often? ____

Do you drink caffeine? Yes☐ No☐
If so, how much and how often? ____

Do you always use your seatbelt when you drive or ride in a vehicle? ? Yes ☐ No ☐

Do you play sports? Yes ☐ No ☐
If so, please list all sports participated in throughout the year: ______________________________
____

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SYSTEM REVIEW

Instructions: Please circle any of the following that apply to your RECENT health.

Constitution

Fever

Chills

Weight Loss

Malaise/Fatigue

Diaphoresis (sweating)

Weakness

Skin

Rash

Itching

HENT

Headaches

Hearing Loss

Tinnitus (ringing in ears)

Ear pain

Ear discharge

Nosebleeds

Congestion

Stridor

Sore Throat

Eyes

Blurred vision

Double vision

Photophobia(light sensitivity)

Eye pain

Eye discharge

Eye redness

Cardiovascular

Chest pain

Palpitations (fast heart beat)

Orthopnea (shortness of breath when laying flat)

Claudication (calf pain w/ walking)

Leg swelling

PND (waking up w/shortness of breath)

Respiratory

Cough

Hemoptysis (coughing up blood)

Sputum production

Shortness of breath

Wheezing

Gastrointestinal

Heart Burn

Nausea

Vomiting

Abdominal pain

Diarrhea

Constipation

Blood in stool

Melena (black sticky stool)

Genitourinary

Dysuria (pain w/urination)

Urgency

Frequency

Hematuria (Blood in urine)

Flank pain

Musculoskeletal

Myalgias (Muscle Pains)

Neck Pain

Back Pain

Joint Pain

Falls

Endo/Heme/Allergy

Easy bruise/bleed

Environ. Allergies

Polydipsia (excessive thirst)

Neurologic

Dizziness

Tingling

Tremor

Sensory change

Speech change

Focal weakness

Seizures

LOC (passing out)

Psychiatric

Depression

Suicidal Ideas

Substance abuse

Hallucinations

Nervous/Anxious

Insomnia

Memory loss

I have read all of the above and I agree that all UNMARKED responses are NOT symptoms that apply to my recent health.

Please Sign:____ Date: _______________________