TEXAS HEALTH CARE
NEW PATIENT HISTORY FORM

Date: _____

Name: _____ Birth Date: _____ Primary Care Physician: _____

Marital Status: _____ Occupation: _____

Reason For Visit: _____

MEDICAL HISTORY: (past and present)

_____ Anemia
_____ Asthma/Bronchi is/COPD
_____ Blood Clots
_____ Diabetes
_____ Gallstones/Kidne Stones
_____ Headaches
_____ Hearing Problem
_____ Heart Disease
_____ Hernia
_____ High Blood Pressure
_____ History of Hepatitis
_____ Hot Flashes/Night Sweats
_____ Muscle, nerve, joint problems
_____ Osteoperosis
_____ Seasonal Allergies
_____ Seizure Disorder
_____ Stomach Ulcers
_____ Stroke
_____ Thyroid Disorder
_____ Tuberculosis/Positive PPD
_____ UTT/Kidney Infections
_____ Visual Problems

*Past Surgeries:

Type Of Surgery	Year	Reason

Blood Transfusions: Yes/ No _____ If Yes, how many units _____ Reason: _____

In case of emergency w uld you accept blood transfusion: Yes/No _____

GYNECOLOGY HISTORY:

____ Difficulty Getting regnant _____ Sexually Active _____Number of Sexual Partners (last 6 months) ____ Male____Female

____ STD's ____ Pain w/ Intercour.se

*Last Menstrual Cycle:_____ / _____ /_____ *Cycle History: Regular _____ Irregular_____ Heavy _____ Painful_____

*Onset Age: _____ *Cycle every_____days *Length_____days

____ Menopausal ____ Hysterectomy ____ Hyst. w/ovaries removed ____ Hyst. w/ one ovary removed ____ Ablation

*Last Pap Smear:_____ /_____ /_____ Results: _____

History Of Abnorm I Pap Smear: _____ If Yes, when:_____ /_____ /_____

Treatment: _____

*Last Mammogram:_____ /_____ /_____ Results: _____

*Last Bone Density:_____ /_____ /_____ Results: _____

*Last Colonoscopy:_____ /_____ /_____ Results: _____

*Current Contraception: _____ *Drug Allergies: _____

Contraceptions used in the past: _____

Last Annual Blood Work:_____/ _____ /_____ Done by: _____

Name:_____ Date:_____

PREGNANCY HISTORY:

*Total Pregnancies: _____ Living Children _____ Miscarriages _____ Abortions _____

Month/Year	Sex	Birth Weight	Weeks Pregnant	Delivery Type	Complications

FAMILY HISTORY: (please indicate family member: mother, father, siblings, maternal/paternal grandparent)

_____ Negative Family History (Alive I Well) _____ Adopted

_____ Breast Cancer
_____ Ovarian Cancer
_____ Colon Cancer
_____ Cancer, other
_____ Diabetes
_____ Seizure Disorder
_____ Osteoarthritis
_____ Osteoperosis
_____ Tuberculosis
_____ Heart Disease
_____ Stroke
_____ High Blood Pressure
_____Rheumatoid Arthritis
_____Skin Disease
_____Kidney Disease
_____Lung Disease
_____Thyroid Disease
_____Blood Clots

SOCIAL HISTORY:

		Details:
Caffeine	___Yes ___No	Amount Daily: _____
Alcohol	___Yes ___No	Frequency: _____
Tobacco	___Yes ___No	What: _____ How Often: _____
		Tried to quit:___Yes ___No When: _____
Substance Abuse	___Yes ___No	_____
Domestic Violence	___Yes ___No	_____
Exercise	___Yes ___No	How often:_____ What kind: _____

MEDICATIONS	DOSAGE	TREATMENT FOR

PREFERRED PHARMACY_____