TEXOMACARE

CHART NO: _____

DATE: _____

PATIENT'S PERSONAL HISTORY

Patient Demographics Updated: _____ Confidential Record: Information will not be released without authorization.

Last Name	First Name	Middle Initial	Birth Date	Birth Place

Occupation: _____ Employer: _____ Employer's Phone: _____
Emergency Contact: _____ Relationship: _____ Phone: _____
Date of Last Physical Exam: _____ Doctor: _____
Family or Referring Physician: _____
Reason for Visit: _____

_____

DRUG ALLERGIES: _____

Family History			**If Living**		**If Deceased**	
			Age	Health	Age at Death	Cause
Father						
Mother						
Brothers/Sisters	Sex		Age	Health	Age at Death	Cause
	M	F				
	M	F				
	M	F				
	M	F				
Sons/Daughters	Sex		Age	Health	Age at Death	Cause
	M	F				
	M	F				
	M	F				
	M	F				

Immunizations Current: ☐ Yes ☐ No Dates of Last Tetanus: _____ Last Flu: _____ Last Pneumonia: _____

Do you know of any **BLOOD RELATIVE** who has had: (Circle and give relationship.)

Stroke: _____ High Blood Pressure: _____
Cancer: _____ Thyroid Problem or Goiter: _____
Heart Attack: _____ Bleeding Disorder: _____
Diabetes: _____ Tuberculosis: _____
Kidney Disease: _____

Personal Habits: (Circle yes or no.)

Yes No Do you use tobacco? What kind? _____ For how many years? _____
Yes No Do you drink alcohol? What kind? _____ How often? _____
Yes No Do you use any street drugs? What kind? _____ How often? _____

List all medications you take and the dose: _____

_____

_____

Please complete the back page of this form.

Write in the names and year of any operations you have had:

Hysterectomy: _____ Other: _____

Heart Surgery: _____

Abdominal Surgery: _____

Cancer Surgery: _____

Circle or write in the names of chronic medical problems you have had and for how long:

Diabetes High Blood Pressure Kidney Disease Lung Disease Heart Disease Cancer

Other: _____

Women Only	Men Only
Are you having regular periods? _____	Have you had prostate problems? _____
Date of last period? _____	_____
How many pregnancies? _____	Have you had any hernias? _____
Date of last pap smear: _____	_____
Have you had an abnormal pap smear? _____	Date of last PSA test: _____
Date of last mammogram: _____	_____

Review of Systems: (Circle yes or no and explain.)

Yes	No	Any fevers, sweats, or weight change?	_____
Yes	No	Any stomach or bowel complaints?	_____
Yes	No	Any headaches, dizzy spells, or weakness?	_____
Yes	No	Any problems with eyes?	_____
Yes	No	Any problems with ears, nose, or throat?	_____
Yes	No	Any chest pain?	_____
Yes	No	Any shortness of breath or cough?	_____
Yes	No	Any problem with bladder or kidneys?	_____
Yes	No	Any problem with back, joints, or feet?	_____
Yes	No	Any problem with nerves, depression, etc?	_____
Yes	No	Any increase in thirst?	_____