F.W. HUSTON MEDICAL CLINICS

(For patients > 10 years old)

Name: _____ Date of Birth: _____

Reason for visit, concerns: _____

Your Primary Physician/Provider: _____ **Specialists:** _____

Age: _____ How would you rate your current health? ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Current Medications: ❑ None

List all medications, dosage (mg), and how often you take them. Include nonprescription drugs.

_____ _____

_____ _____

_____ _____

_____ _____

Drug Allergies (list reaction): ❑ None

_____

_____

_____

_____

Surgeries and Hospitalizations: ❑ None

_____

_____

_____

_____

Current or Chronic Medical Problems: ❑ None

Have you ever been diagnosed or treated for any of the following?

❑ Anemia
❑ Arthritis, type _____
❑ Asthma / Lung disease
❑ Bleeding / Blood clots
❑ Depression / Nervous problem
❑ Diabetes
❑ Heart disease
❑ High blood pressure
❑ High cholesterol
❑ Sleep Apnea
❑ Kidney disease / stones
❑ Liver disease
❑ Cancer, type: _____
❑ Migraine headaches
❑ Osteoporosis
❑ Stomach / Intestinal disease
❑ Stroke
❑ Thyroid disease, type _____
❑ Other problems: _____

Preventive Care: When was your most recent?

Tetanus booster _____
Hepatitis B vaccine _____
Pneumonia vaccine _____
Women: Pap smear _____
Flu shot _____
TB skin test (PPD) _____
Eye exam _____
Mammogram _____
Colonoscopy / Sigmoidoscopy _____
PSA test (prostate) _____
Dental exam __ _____
Bone Mineral Density _____

Family history: Have any close relatives (parents, brothers, sisters, etc.) had the following?

❑ Allergies / Asthma
❑ Blood or clotting disorders
❑ Depression / psychiatric illness
❑ Diabetes
❑ Heart disease
❑ Hereditary disease
❑ High blood pressure
❑ High cholesterol
❑ Stroke
❑ Cancer, types: _____
❑ Other serious illness: _____

Father: ❑ Living, age: ___ ❑ Deceased at age: ___ Cause of death: _____

Mother: ❑ Living, age: ___ ❑ Deceased at age: ___ Cause of death: _____

Social History: Marital status: _____ Occupation: _____

Number of children living: _____ Who lives with you? _____

Do you ever feel afraid or unsafe at home? __Yes __ No Have you ever been abused? _____
Advanced Directive/Living will? __Yes __ No Have you used street drugs? __Yes __ No _____
Over the past month, have you felt down, depressed or hopeless? _Yes _No; Had little interest in doing things? _Yes _No

Do you use tobacco? __Yes __ No
How much? _____
If you quit, when? _____

Do you drink alcohol? __Yes __ No
How much? _____
If you quit, when? _____

Do you exercise regularly? __Yes __ No
What type? _____
How much? _____

Signature of Responsible Party: _____Today's Date: _____