

**University of Texas Health Services  
7000 Fannin, Suite 1620  
Houston, Texas 77030**

**Patient History Form**

Name \_\_\_\_\_  
Date \_\_\_\_\_

Social Security # \_\_\_\_\_

**PAST HISTORY AND REVIEW OF SYSTEMS**

Please check the problem if you have ever had any of the following:

1. \_\_\_ Weight Loss or Gain of more than 5 pounds:
2. \_\_\_ Anemia/Bleeding Disorders:
3. \_\_\_ Skin Problems:
4. \_\_\_ Asthma/Emphysema:
5. \_\_\_ Shortness of Breath:
6. \_\_\_ Persistent or Unusual Cough:
7. \_\_\_ Tuberculosis, BCG Vaccine or a Positive TB Skin Test:
8. \_\_\_ Loss of Consciousness/Seizures/Convulsions:
9. \_\_\_ Frequent Headaches:
10. \_\_\_ Difficulty Sleeping:
11. \_\_\_ Unsteadiness in Balance/Dizzy Spells:
12. \_\_\_ Hepatitis/Liver Disease/Gallstones:
13. \_\_\_ Kidney Disease/Kidney Stones/Urinary Infection:
14. \_\_\_ Sexually Transmitted Diseases:
15. \_\_\_ Diabetes/Sugar Disorders:
16. \_\_\_ Neck/Back/Knee Problems:
17. \_\_\_ Cancer/Tumor/Leukemia:
18. \_\_\_ Arthritis/Rheumatism:
19. \_\_\_ Difficulty with Ears or Hearing Loss:
20. \_\_\_ Sinus Problems other Than Colds:
21. \_\_\_ Color Blindness/Vision Problems:
22. \_\_\_ High Blood Pressure/Heart Disease/Heart Murmur:
23. \_\_\_ Chest Pain/Tightness or Discomfort:
24. \_\_\_ Heart Palpitations or Skipped Beats:
25. \_\_\_ Swelling of your Ankles:
26. \_\_\_ Digestive Problems/Ulcer/Bowel Disease:
27. \_\_\_ A Change in Bowel Habits:
28. \_\_\_ Thyroid Problem:
29. \_\_\_ Joint Pains or Arthritis:
30. \_\_\_ Alcohol/Drug Treatment/Drunk Driving Arrest:
31. \_\_\_ Psychiatric/Emotional Problems/Depression/Anxiety:
32. \_\_\_ Sexual or Physical Abuse:
33. \_\_\_ Unusual Stress in Your Work/Home Life:
34. \_\_\_ Allergy to Medication:List: \_\_\_\_\_
35. \_\_\_ Surgery (list with dates) \_\_\_\_\_
36. \_\_\_ Hospitalizations (list with dates) \_\_\_\_\_
37. \_\_\_ Medications (list) \_\_\_\_\_
38. \_\_\_ Immunizations (dates) Tetanus: \_\_\_\_\_ Hepatitis B: \_\_\_\_\_ MMR: \_\_\_\_\_

MALES ONLY

Please check the problem if it pertains to you \_\_\_\_

Do you:

- 1. \_\_\_\_ Have/Had Prostate Trouble?
- 2. \_\_\_\_ Perform Monthly Self Testicular Exams?
- 3. \_\_\_\_ Have More than 1 Female Sex Partner?
- 4. \_\_\_\_ Have/Had a Male Sex Partner?
- 5. \_\_\_\_ Always use Condoms?

FEMALES ONLY

Please check the problem if it pertains to you.

- 1. \_\_\_\_ Have Irregular Menstrual Periods?
- 2. \_\_\_\_ Have Problems with your Periods?
- 3. \_\_\_\_ Have any Bleeding/Spotting after Sex?
- 4. \_\_\_\_ Have pain with Intercourse?
- 5. \_\_\_\_ Have more than 1 Sex Partner?
- 6. \_\_\_\_ Have/Had an Abnormal Pap Smear?
- 7. \_\_\_\_ Ever Been Pregnant?
- 8. \_\_\_\_ Ever Miscarried or Had an Abortion?
- 9. \_\_\_\_ Perform Monthly Breast Exams?
- 10. \_\_\_\_ Type of Contraception used if Sexually Active:
- 11. \_\_\_\_ Date of Last Pap: \_\_\_\_\_ Date of Last Mammogram: \_\_\_\_\_

FAMILY MEDICAL HISTORY

Please check the problem and indicate which family member has had:

- 1. \_\_\_\_ Alcoholism:                      Who: father mother
- 2. \_\_\_\_ Allergies of Any Kind:                      Who:
- 3. \_\_\_\_ Asthma:                      Who:
- 4. \_\_\_\_ Bleeding Problems/Tendencies:                      Who:
- 5. \_\_\_\_ Cancer of Any Type:                      Who:
- 6. \_\_\_\_ Diabetes or Sugar in Urine:                      Who:
- 7. \_\_\_\_ Convulsions or Epilepsy:                      Who:
- 8. \_\_\_\_ Glaucoma:                      Who:
- 9. \_\_\_\_ Heart Trouble of Any Kind:                      Who:
- 10. \_\_\_\_ High Blood Pressure or Hypertension:                      Who:
- 11. \_\_\_\_ Kidney Problems of Any Type:                      Who:
- 12. \_\_\_\_ Nervous Breakdown or Emotional Problems:                      Who:
- 13. \_\_\_\_ Rheumatism or Arthritis:                      Who:
- 14. \_\_\_\_ Stomach Trouble or Ulcer:                      Who:
- 15. \_\_\_\_ Stroke:                      Who:
- 16. \_\_\_\_ Tuberculosis:                      Who:

PERSONAL HISTORY

Please check yes or no.

Yes    No

- \_\_\_\_    \_\_\_\_ 1. Use Tobacco? (Now or in the Past)
- \_\_\_\_    \_\_\_\_ 2. Have Problems with Alcohol? (Now or Past)
- \_\_\_\_    \_\_\_\_ 3. Wear Seat Belts?
- \_\_\_\_    \_\_\_\_ 4. Exercise?
- \_\_\_\_    \_\_\_\_ 5. Have Dietary Restrictions?
- \_\_\_\_    \_\_\_\_ 6. Own a Firearm?