PATIENT GENERAL INFORMATION Date:_____

NOTE: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.

*NAME_____ *DATE OF BIRTH:_____

OCCUPATION_____ *RACE: __White__African American/Black
__Native Hawaiian/Other Pacific Island
__Asian__American Indian/Alaska Native
__Other_____

MARRIED___ WIDOW (ER) ___
SINGLE___ DIVORCED___
DOMESTIC PARTNER ___

*ETHNICITY:_____
i.e..European, German, Mexican etc…
*PREFERRED LANGUAGE:_____

PERSONAL HEALTH HISTORY			DATE OF DIAGNOSIS (OR APPROXIMATE)
Heart attack / angina	NO	YES	_____
Heart failure	NO	YES	_____
Stroke	NO	YES	_____
High blood pressure	NO	YES	_____
High cholesterol	NO	YES	_____
Asthma	NO	YES	_____
COPD or emphysema	NO	YES	_____
Colitis or bowel disease	NO	YES	_____
Liver disease	NO	YES	_____
Kidney disease	NO	YES	_____
Bone or joint disease	NO	YES	_____
Diabetes	NO	YES	_____
Thyroid disease	NO	YES	_____
Migraines	NO	YES	_____
Allergies	NO	YES	_____
Skin disease	NO	YES	_____
Cancer	NO	YES	_____
Depression	NO	YES	_____
Anxiety	NO	YES	_____
Sexually transmitted disease	NO	YES	_____
Other	NO	YES	_____

SURGERIES AND DATES PERFORMED

_____
_____
_____
_____
_____
_____
_____

HOSPITALIZATIONS OTHER THAN SURGERIES

_____
_____
_____
_____
_____
_____
_____

HISTORY OF INJURIES:

Broken Bones	NO	YES	SPECIFY_____
Dislocations	NO	YES	SPECIFY_____
Concussion, or Head Injury	NO	YES	SPECIFY_____

DO YOU SMOKE TOBACCO?	NO	YES	PACKS PER DAY_____
HAVE YOU EVER SMOKED TOBACCO?	NO	YES	HOW LONG_____
DO YOU DRINK ALCOHOL?	NO	YES	DRINKS PER WEEK_____
DO YOU DRINK CAFFEINATED DRINKS	NO	YES	CUPS PER DAY_____
			(INCLUDING COFFEE, TEA, & COLA)

PLEASE TURN OVER

DRUG ALLERGIES

_____ _____ _____
_____ _____ _____

LONGTERM PRESCRIPTION MEDICATION YOU:

ARE CURRENTLY TAKING	HAVE TAKEN IN THE PAST
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

HAVE YOU EVER HAD BLOOD OR PLASMA TRANSFUSION?_____

DATE OF LAST DIPHTHERIA-TETANUS BOOSTER_____

WOMEN:

Date of last menstrual period_____
Do you use birth control? _____ If yes, what kind? _____
Date and result of last Pap Smear Date_____ Result_____

LIST PREVIOUS DOCTORS IN AUSTIN WHO HAVE TREATED YOU:

_____ _____ _____
_____ _____ _____

FAMILY HISTORY	PLEASE CIRCLE		FAMILY MEMBERS
Heart attack / angina	NO	YES	WHO_____
Stroke	NO	YES	WHO_____
High blood pressure	NO	YES	WHO_____
High cholesterol	NO	YES	WHO_____
Cancer	NO	YES	WHO_____ KIND_____
			WHO_____ KIND_____
			WHO_____ KIND_____
Asthma	NO	YES	WHO_____
Tuberculosis	NO	YES	WHO_____
Diabetes	NO	YES	WHO_____
Thyroid disease	NO	YES	WHO_____
Bone or joint disease	NO	YES	WHO_____
Allergies	NO	YES	WHO_____
Eczema	NO	YES	WHO_____
Anxiety	NO	YES	WHO_____
Depression	NO	YES	WHO_____
Other diseases	NO	YES	WHO_____ WHAT_____
			WHO_____ WHAT_____
			WHO_____ WHAT_____

PLEASE PROVIDE S.A.M.C. WITH COPIES OF ANY ADVANCED DIRECTIVE SUCH AS MEDICAL POWER OF ATTORNEY, DNR, ETC.