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

Patient History Form

Name: ____ Date: ________________________

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?