UNIVERSITY OF TEXAS PHYSICIANS CENTRAL TEXAS

INTERNAL MEDICINE
NEW PATIENT INFORMATION (16 YEARS +)

Adult Health History (16 years or older)

Name: _____ **DOB:** ____/____/____ **Sex M** _____ **F** _____

Past Medical History (*Check all items that apply to you and fill in blanks as needed.)*:

_____Allergies

_____Anemia or blood problems

_____Arthritis

_____Asthma

_____Birth defects_____

_____Blood transfusion, year _____

_____Cancer / tumor, explain _____

_____Chicken pox

_____Colon disease

_____COPD, Emphysema, lung disease

_____Diabetes type _____how long _____

_____Drug / alcohol abuse

_____Epilepsy

_____Hearing loss

_____Heart disease / attack

_____Hepatitis A B C / Jaundice

_____HIV / AIDS

_____Hypertension

_____Hypothyroid / Hyperthyroid

_____Inherited disease

_____Kidney disease / stones

_____Mental illness / depression

_____Pap smear abnormal

_____Peptic Ulcer Disease/GERD

_____Sexually transmitted disease (STD)

_____Sickle Cell Anemia / trait

_____Skin disease, eczema, psoriasis

_____Stroke

_____Other _____

_____

Past Surgical / Hospitalization History:

_____Angioplasty

_____Appendectomy

_____Back procedure _____

_____Breast procedure R / L _____

_____Cervical freezing / LEEP

_____Fracture _____

_____Gallbladder

_____Hernia R / L _____

_____Hysterectomy (uterus)

_____Hysterectomy (ovaries)

_____Knee R/L _____

_____Psychiatric treatment in/outpatient

_____Vasectomy

_____Other _____

For office use only:

_____ _____

Initials Date

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NEW PATIENT INFORMATION (16 YEARS +)

PATIENT NAME: _____

Last Lab work/Radiology:

Lipid / Cholesterol Panel_____ TSH_____ CBC_____

Chest X-Ray_____ EKG _____

Colonoscopy_____ Bone Density _____

Females Only:

Age at first period: _____ Birth Control Method: _____

Number of: Pregnancies _____ Live births _____ Miscarriages _____ Abortions _____

Date of last: Period _____ Pap smear _____ Mammogram _____

Males Only:

Last Physical Exam _____ Prostate Exam _____ PSA _____

Drug Allergies:

_____ No known drug allergies

Name of Drug Reaction

_____

_____

_____

Current Medications: (*please include all prescription, birth control pills, over the counter, herbs and vitamins)*

Medication Dose and Frequency Medication Dose and Frequency

_____

_____

_____

Immunizations / Injections: (*please put year of last injection)*

_____ Tetanus Booster _____ Hepatitis B _____ Other _____

_____ Flu Vaccine _____ Hepatitis A

_____ Pneumonia Vaccine _____ TB Skin Test

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PATIENT NAME: _____

Social History

Tobacco: Cigarettes / Chew / Snuff: How much per day: _____ for how long: _____

Alcohol: How many per day / week / month: _____

Caffeine: Number of cups of coffee per day / week / month: _____

Number of cups of tea per day / week / month: _____

Number of cups of soda per day / week / month: _____

Do you exercise? Yes / No How Often: _____

Are you sexually active? Yes / No New Partner in the last year? Yes / No

Are you a victim of abuse? Yes / No _____Physical Sexual _____Mental _____Verbal

Who is / was the abuser? _____

Do you use a seat belt? Yes / No

Have you been exposed to hazardous materials? _____

Have you served in the military service? What branch? _____

Are you on a special diet / vegetarian? _____

Do you travel to foreign countries? Where? _____

Family History

	Living Age	Healthy/Illness	Deceased Age	Healthy/Illness
Father:	_____	_____	_____	_____
Mother:	_____	_____	_____	_____
Father's Father:	_____	_____	_____	_____
Father's Mother:	_____	_____	_____	_____
Mother's Father:	_____	_____	_____	_____
Mother's Mother:	_____	_____	_____	_____

PATIENT NAME: _____

For office use only:

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	Living Age	Healthy/Illness	Deceased Age	Healthy/Illness
Brothers:				
Sisters:				
Children:				

Signature of Patient or Parent: _____ Date: / /

Provider Review Signature: _____ Date: / /

Rev. Dec. 2008

2008/09

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Initials _____ Date _____