Dallas Medical
Doctors of Internal Medicine

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NEW PATIENT HISTORY FORM

Note: This is a confidential record and will be kept in your doctor's office. Information contained here will not be released to anyone without your authorization to do so.

Name: _____ **DOB:** _____

Medical History

ALL medications and supplements taken regularly: [ ] Separate list attached

Drug Name	Dose	# Times / day	Drug Name	Dose	# Times / day

Allergies to medications: [ ] No known drug allergies [ ] Separate list attached

Drug	Reaction	Drug	Reaction

Previous surgeries: [ ] Separate list attached

Date	Type of surgery	Date	Type of surgery

Previous hospitalizations *not including* surgeries [ ] Separate list attached

Date	Reason	Date	Reason

All medical problems not listed above: [ ] Separate list attached

Date	Problem	Date	Problem	Date	Problem

Family History

History of disease in family (blood relatives only):

Disease	Relation	Age diagnosed	Disease	Relation	Age diagnosed
[ ] Colon Cancer			[ ] Diabetes		
[ ] Breast Cancer			[ ] Heart Disease		
[ ] Ovarian Cancer			[ ] Stroke		
[ ] Prostate Cancer			[ ] High Cholesterol		
[ ] High Blood Pressure			[ ] Other		

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PATIENT HISTORY FORM

Social History

Smoking History: [ ] Yes: Number of packs per day: _____
Number of years smoked: _____ Year Quit: _____
[ ] Never smoked

Number of alcoholic drinks/day on average: ____ Number of caffeinated drinks/day on average: _____

Drug abuse history: [ ] None [ ] Past [ ] Current

Marital Status: [ ] Married [ ] Single [ ] Divorced [ ] Widowed [ ] Partnered

Occupation: _____

Do you exercise regularly?
[ ] Yes Type(s) of activity: _____ Hours per week: ___
[ ] No

Do you have any tattoos? [ ] Yes [ ] No
Have you ever received a blood transfusion? [ ] Yes [ ] No
Do you wear a seat-belt regularly? [ ] Yes [ ] No
Do you have a carbon monoxide detector? [ ] Yes [ ] No

Preventive Health History

Have you had a colonoscopy? [ ] Yes Date:_____ [ ] No
Have you had a cardiac stress test? [ ] Yes Date:_____ [ ] No
Have you had a bone density scan? [ ] Yes Date: _____ [ ] No

Date of last eye exam: _____
Date of last skin exam: _____
Date of last dental exam: _____

Immunizations:
[ ] Flu Vaccine Date: _____ [ ] Shingles Vaccine
[ ] Pneumonia Vaccine Date: _____ [ ] Cervical Cancer Vaccine
[ ] Tetanus Vaccine Date: _____ [ ] Hepatitis B Vaccine

Women:
Number of pregnancies: ___ Number of miscarriages: ___
Date of last PAP smear: _____
Have you had an abnormal PAP smear? [ ] Yes [ ] No
Date of last mammogram: _____
Have you had an abnormal mammogram? [ ] Yes [ ] No
Do you perform regular self breast-exams? [ ] Yes [ ] No

Men:
Date of last rectal exam: _____
Date of last PSA: _____
Have you had an abnormal PSA level? [ ] Yes [ ] No
Do you perform regular self testicular exams? [ ] Yes [ ] No

Patient Signature: _____ Date: _____