Name ______________________

DOB ________________________

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520 Camden
San Antonio, Texas 78215
210-223-3246

List names of Specialists and what they are treating you for

____

____

Preventative Care:		
List Vaccines	**Dates**	
FLU		
Pneumonia		
Tetanus		
Shingles		
MMR		
Chicken Pox		
Hepatitis B		
Gardasil		
Covid-19	**#1**	
	#2	
Procedure Test		
Colonoscopy		
Men: Date of last PSA		
Rectal Exam		
Women: Date of last Pap		
Mammogram		
Eye Exam **Diabetic Retinal Exam**		
DEXA		

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Initial Health History Form

Name ___________________________

Date of Birth _____________________

Date ____________________________

What is the reason for your initial appointment?

____

Who referred you? __________________________________

Personal Medical History:					
Please check ☐ any of the following that you have been diagnosed with:					
Diabetes		Circulation Problems		Psoriasis	
High Blood Pressure		Kidney Disease		Eczema	
High Cholesterol		Kidney Stones		Rosacea	
Heart Attack		Recurrent Urine Infections		Other Skin Disorders	
Heart Murmur		Enlarged Prostate		Sleep Apnea	
Atrial Fibrillation		Erectile Dysfunction		Asthma	
Aneurysm		Prostate Cancer		COPD / Emphysema	
Rheumatic Fever		Hepatitis A B C		Bronchitis	
Congestive Heart Failure PAD		Cirrhosis		Pneumonia	
Thyroid Disease		Liver Disease		Anemia	
Adrenal Gland Disorder		Parathyroid Adenoma		Leukemia	
Depression		Bipolar		Blood Clotting Disorder	
Anxiety / Panic Attacks		Other Mental Illness		TB	
Suicide Attempt		Rheumatoid Arthritis		HIV	
Peptic Ulcer		Lupus		MRSA	
Reflux		Gout		Syphilis	
Hiatal Hernia		Fibromyalgia		Gonorrhea	
Colon Polyps		Chronic Pain		VD	
Ulcerative Colitis		Herniated Disc		Neuropathy	
Crohn’s		Neck Problems		Nerve Damage	
Irritable Bowel		Migraine Headaches		Multiple Sclerosis	
Hemorrhoids		Tension Headaches		Stroke	
Osteoporosis		Seizures		Dementia	
Osteoarthritis		Acne		Alzheimer’s	
Parkinson’s		Glaucoma		Retinopathy	

Any other major or chronic medical problems please list: ________________________________

Ever Have Any Blood Transfusions YES _____ NO _____

Name ______________________

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Surgeries:

Please check ☐ any of the following surgeries:

Heart Bypass		Appendix		Back	
Leg Bypass		Gallbladder		Hip	
Valve Replacement		Tonsils		Knee	
Pacemaker		Prostate		Thyroid	
Heart Stent		Tubal Ligation		Hernia	
Carotid		C-Section		Abscess	
Heart Cath		Hysterectomy		Cosmetic Surgery	

List any other surgeries

List All Hospitalizations and approximate date:

Allergies to medications and what was the reaction:

1.		7.	
2.		8.	
3.		9.	
4.		10.	
5.		11.	
6.		12.	

BRING ALL BOTTLES OF CURRENT MEDICATIONS

If you do not have, please list.

1. ____
2. ____
3. ____
4. ____
5. ____

Name _______________________

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Family Medical History

Please check ☐ if any of your blood relatives have:

Diabetes		Depression		Cancer of:	
Premature Heart Disease		Alcoholism		Breast	
High Blood Pressure		Blood clots		Colon	
Aneurysms		Bleeding disorder		Ovaries	
Kidney Failure		Thyroid Disease			

Health History of:

Mother	Living		Has history of: _________________________ died age _____________
	Well		
	Age		From ______________________________________
Father	Living		Has history of: _________________________ died age _____________
	Well		
	Age		From ______________________________________

Health status or cause of death of brothers and sisters:

Social History

What kind of work do you do?

If retired, from what?

If disable. Disabled due to what?

Who do you live with?

Name ________________________

DOB __________________________

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Please check ☐ all that apply:					
Single		Smoker		Alcoholism	
Married		Ex -Smoker		Tattoos	
Widowed		Non-Smoker		Piercing	
Divorced		History of drug abuse		Multiple Sex Partners	
Significant Other		IV Drug Use			
Education:					
Did not finish high school					
High School					
Some College					
College Degree in					
Masters					
PhD					
Do you have a DNR or Living Will?	Yes ☐ No ☐				

May we contact you by email regarding results or appointments? Yes ☐ NO ☐

If yes, initial here _________

Email Address ___________________________________