

CONFIDENTIAL MEDICAL HISTORY
Provided solely for use by
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And
DALLAS DIAGNOSTIC ASSOCIATION

Name: _____ Today's Date: _____

Age: _____ Sex: _____ Marital Status: _____ Occupation: _____

What is the reason you are seeing the doctor? _____

How long has this been a problem? _____

Have you seen other doctors for this problem? _____ What did they advise? _____

Did another doctor suggest that you come to our office? _____

SURGERY

Please ✓ any surgery you have had

- | | | |
|--|----------------------------------|---|
| <input type="checkbox"/> tonsils | <input type="checkbox"/> heart | <input type="checkbox"/> C-section |
| <input type="checkbox"/> appendix | <input type="checkbox"/> lung | <input type="checkbox"/> hysterectomy |
| <input type="checkbox"/> gallbladder | <input type="checkbox"/> thyroid | <input type="checkbox"/> one/both ovaries |
| <input type="checkbox"/> ulcer surgery | <input type="checkbox"/> eye | <input type="checkbox"/> "tubes tied" |
| <input type="checkbox"/> intestine | <input type="checkbox"/> ear | <input type="checkbox"/> "D&C" |
| <input type="checkbox"/> kidney | <input type="checkbox"/> nose | <input type="checkbox"/> breast |
| <input type="checkbox"/> bladder | <input type="checkbox"/> sinus | <input type="checkbox"/> back |
| <input type="checkbox"/> prostate | <input type="checkbox"/> dental | <input type="checkbox"/> joints/bones |
| <input type="checkbox"/> skin | | |

Describe any other surgery: _____

Describe any poor results from surgery: _____

CURRENT MEDICATION

Name	Strength (mgs)	Circle Number of Times per Day
_____	_____	1 ___ 2 ___ 3 ___ 4 ___ more
_____	_____	1 ___ 2 ___ 3 ___ 4 ___ more
_____	_____	1 ___ 2 ___ 3 ___ 4 ___ more
_____	_____	1 ___ 2 ___ 3 ___ 4 ___ more
_____	_____	1 ___ 2 ___ 3 ___ 4 ___ more

MEDICATION ALLERGIES

Name of Medicine	Describe what problem it causes
_____	_____
_____	_____
_____	_____

How often do you use the following medicines?

Aspirin (Bufferin, Anacin, Excedrin, etc.) _____ Never _____ Occasionally _____ Often _____ Daily _____
Ibuprofen (Advil, Medipren, Motrin, etc.) _____ Never _____ Occasionally _____ Often _____ Daily _____
Antacids (Mylanta, Rolaids, Tums, etc.) _____ Never _____ Occasionally _____ Often _____ Daily _____
Laxatives _____ Never _____ Occasionally _____ Often _____ Daily _____
Medicine for diarrhea _____ Never _____ Occasionally _____ Often _____ Daily _____
Tranquilizers _____ Never _____ Occasionally _____ Often _____ Daily _____
Sleeping pills _____ Never _____ Occasionally _____ Often _____ Daily _____
Decongestants/Antihistamines _____ Never _____ Occasionally _____ Often _____ Daily _____

✓ Mark if you have EVER used medication for:

<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Heart medication	<input type="checkbox"/> Seizures
<input type="checkbox"/> Water pills (diuretic)	<input type="checkbox"/> Steroids
<input type="checkbox"/> Blood thinner	<input type="checkbox"/> Thyroid
<input type="checkbox"/> Asthma	<input type="checkbox"/> Arthritis pills

When is the last time you were hospitalized overnight? _____

What was the reason for being in the hospital? _____

SMOKING

Do you smoke? _____ How many packs per day? _____

Have you EVER smoked? _____ When did you quit? _____

ALCOHOL

How often do you drink? _____ Never _____ Rarely _____ Occasionally _____ Often _____ Daily _____

Which of these do you drink? _____ Beer _____ Wine _____ Hard Liquor

How much do you ordinarily drink when you are drinking? _____

DRUGS

Have you every used drugs except as prescribed by a doctor? _____

Are you for any reason at increased risk of getting AIDS? _____

TRAUMA

Describe any major accidents or injuries _____

Have you ever been knocked unconscious? _____ Under what circumstances? _____

Is there anything else the doctor should know? _____

