UT MEDICINE CTRC
HEALTH SCIENCE CENTER
SAN ANTONIO

Patient Label

NEW PATIENT HISTORY DATABASE

Please complete the following questionnaire. Leave blank any parts you are unsure of, or do not wish to answer. Your answers will help with providing your care. We will review this form with you during your examination. All information will be kept confidential.

Patient Name: ____ **Date of Birth:** _________________

Place of Birth (City & State): ____

Who referred you to our office? ____

Who is your Primary Doctor? ____

What Pharmacy do you use (HEB, CVS, Walmart, etc.)? _____________________________________

What is a good contact number for the doctor to reach you? ________________________________

What is the reason for your visit today?

____

____

History of your current problem (when it started, your symptoms and treatment if any**):**

____

____

Tobacco Use: YES / NO   Type: Cigarettes / Pipe / Cigars   No. per day? ___ No. of Years: ___

Smokeless Tobacco: Never Used / Yes/No   Type: Snuff (between lower lip and gum**) /Chew (**between cheek and gum)

Quit Date: _________________ **Ready to Quit? YES / NO Counseling Given? YES or NO**

Alcohol Use: YES or NO   Comment: ____

Illicit Drug Use: YES or NO   Comment:____

YOUR MEDICAL HISTORY: Please check all previous illness or conditions below.

___ **Chronic Obstructive Pulmonary Disease**
___ **Asthma**
___ **Hypertension (**High blood Pressure**)**
___ **Coronary Artery Disease**
___ **Myocardial Infarction (**Heart Attack**)**
___ **Congestive Heart Failure**
___ **Hyperlipidemia (**High cholesterol or Triglycerides**)**
___ **Diabetes**
___ **Chronic Renal Failure (**Kidney Disease**)**
___ **Obesity**
____ **Hyperthyroidism (**Overactive Thyroid**)**
____ **Hypothyroidism (**Underactive Thyroid**)**
____ **Thyroid Nodule (**Lump in Thyroid Gland**)**
____ **Hyperparathyroidism (**Produce too much Parathyroid Hormone**)**
____ **Hashimoto's Disease (**Thyroid Gland Inflammation**)**
____ **Hypercalcemia (**Too much Calcium in the Blood**)**
____ **Osteopenia (**Mild Bone Loss**)**
____**Osteoporosis (**Severe Bone Loss**)**
____**Vitamin D Deficiency**
____**Kidney Stones**

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Do you have a history of prior cancers?

____

____

Any other problems not listed?

____

Surgical History:
If so, please include the type of surgery and approximate date:

____

____

Have you ever been hospitalized? Yes / No Hospital: ______________________________
Please tell us reason why and when?

____

Are you adopted? Yes / No

Family Medical History			Adrenal Cancer	Brain Tumor	Breast Cancer	Colo-rectal Cancer	Genetic Disease	Kidney Cancer	Leukemia	Liver Cancer	Lymphoma	Melanoma Skin	Ovarian Cancer	Pancreas Cancer	Parathyroid Tumor	Prostate Cancer	Stomach Cancer	Thyroid Cancer	Uterine Cancer	Endometriosis	Bone Cancer	Lung Cancer
Relationship	**Age of Diagnosis**	**Alive (A) or Deceased (D)**																				
Mother																						
Father																						
Sister																						
Brother																						
Maternal Grandmother																						
Maternal Grandfather																						
Paternal Grandmother																						
Paternal Grandfather																						
Daughter																						
Son																						
Paternal Aunt																						
Maternal Aunt																						
Paternal Uncle																						
Maternal Uncle																						
Cousin - Male																						
Cousin - Female																						
Other:																						

Patient Label

Current Medications (*include Hormones, Over the Counter drugs, Vitamins and Herbs*)**:**

Name of Medicine	Dosage	How often Taken	Tablet/ Capsule	Reason for Taking Medicine

Are you allergic to anything? ___ **YES** ___**NO**

List all ALLERGIES to anything and describe your reaction.

Allergy:	Reaction:

Review of Systems: Please check ***all*** of the following problems you are having ***now***.

General
__ Chills
__ Fever
__Decreased Appetite
__ General Discomfort/ Fatigue
__ Night Sweats
__Pain (Location: ___________)
__Weakness
__Weight Gain
__Weight Loss
__Falls

Endocrine
__ Cold Intolerance
__Heat Intolerance
__Diabetes
__Polydipsia (Excessive thirst)
__Hot Flashes

Eyes
__Blurred Vision
__ Double Vision
__Eye Pain
__Tearing
__Vision Changes
__Yellow Eyes

Genitourinary
__Blood in Urine
__Burning Urination
__Difficulty Controlling
__Excessive Urination
__Frequency
__Sexual Dysfunction
__Urgency
__Vaginal Bleeding
__Vaginal Problems
__Mass
__Incontinence

Musculoskeletal
__Back Pain
__Bone Pain
__Joint Pain
__Joint Stiffness
__Muscle Pain
__Muscle Weakness
__Neck Pain
__Trauma / Injury (______)

Hem/Lymph
__Anemia
__Easy Bruise/Bleed
__Lymphedema (Swelling)
__Swollen Glands

Head/ Ears/Nose/ Throat
__Hearing Changes
__Hearing Loss
__Hoarseness
__Mouth Ulcers
__Nose Bleeds
__Otalgia (Ear pain)
__Ringing In Ears
__Runny Nose
__Sore Mouth
__Throat Pain

Respiratory
__Cough
__Coughing Blood
__Shortness Of Breath
__Sputum Production
__Wheezing
__Pleuritic (Chest) Pain

Psychiatric
__Depression
__Hallucinations
__Insomnia
__Anxiety
__Substance Abuse
__Suicidal Thoughts

Gastrointestinal
__Abdominal Pain
__Black Stools
__Blood in Stools
__Constipation
__Diarrhea
__Difficulty Swallowing
__Heartburn
__Nausea
__Painful Swallowing
__Vomiting

Neurological
__Confusion
__Dizziness
__Fainting
__Headache
__Lightheadedness
__Memory Changes
__Numbness: _________
__Paresthesia "pins & needles" feeling
__Seizure
__Speech Changes
__Unbalanced Walking
__Focal Weakness

Breast
__Breast Pain
__Breast Mass
__Nipple Discharge
__Breast Self-Exam
__Skin Changes

Skin
__Bruises
__Bumps
__Changes In Moles
__Itching
__Nail Changes
__Rash
__Skin Changes
__Sores

Cardiovascular
__Chest Pain
__Palpitations
__Leg Swelling
__Leg Pain
__Paroxysmal Nocturnal Dyspnoea (Shortness of breath & coughing @ night)
__Orthopnea

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Patient Signature:_________________________________ Date:________

Physician/Healthcare Provider Signature:__________________________