Trophy Club Family Medicine (817) 430-9111 New Patient rev 11/17

Name _____DOB ___/___/___ Date ___/___/___

Please list ALL current medications, vitamins, herbs or non-food supplements

Medication	Dose	Frequency		Medication	Dose	Frequency

Any chronic or recurring conditions?

Any hospitalizations or major illnesses? Any surgeries (including wisdom teeth)?

Please list any specialists that you have seen in the past few years and why.

_____

_____

_____

_____

_____

Allergies or reactions to medications, or other agents

Medication	Reaction or side effect		Medication	Reaction or side effect

Tobacco use

☐ Never smoked ☐ Current smoker ☐ Former smoker, quit date: _____

Total history of use: Average packs/day: ___ for #of years: ___.

Other tobacco: ☐ pipe ☐ cigar ☐ snuff ☐ chew ☐ other

Alcohol use

Drinks in a typical week _____

Does your drinking worry you or others? ☐ yes ☐ no

Drug use

Have you ever used recreational drugs? ☐ No ☐ Yes: _____

Still using? ☐ No ☐ Yes: _____

Name _____ DOB ____/____/____ Date____/___/____

Average daily caffeine use

coffee: (6oz = 1 serving)_____ # tea_____ # cans of soda_____ # energy drinks_____

Exercise: Any regular exercise? ☐ Yes ☐ No. Type, hours per week:_____

Current occupation: _____ **Occupational hazards**:_____

Average hours worked weekly including commute: _____

Activities and hobbies:_____

Education completed: ☐ grade ☐ high ☐ trade ☐ college ☐ masters ☐ graduate

Marital status: ☐ single ☐ married ☐ divorced ☐ separated ☐ widowed/er ☐ co-habitating

Sexually active ☐ Yes ☐ No

Sex partners are ☐ male ☐ female

Contraception and protection: Birth control method: _____

Have you ever had any sexually transmitted diseases? ☐ Yes ☐ No

If yes, please explain: _____

History of blood transfusion? ☐ Yes ☐ No **Any tattoos?** ☐ Yes ☐ No

Women's gynecologic history:

pregnancies:___ # abortions: ___ # miscarriages:___ # c-sections ___ # vaginal deliveries: ___

1st day, most recent period_____ Age at onset of periods: _____

Frequency of periods: _____ Length of periods: _____

Ever had an abnormal pap? ☐ Yes ☐ No

Personal and Family history

Please note major medical conditions of your family members.

Please be as specific as possible.

Mom: _____

_____

Dad: _____

_____

Children: _____

_____

Other relatives: _____

_____

_____

Name _____ DOB ____/____/____ Date____/___/____

Review of Systems (this is to check for past or recurring issues)

Constitutional:	Y	N
Chronic poor sleep		
Chronic fatigue, excessive sleepiness		
Chronic pain		
Unexplained weight loss or gain		
Neurologic:	Y	N
Recurring dizziness		
Headaches more than 3 per month		
Numbness or tingling		
Ever had seizures		
Significant memory loss		
Eyes/ears/nose/mouth:	Y	N
Eye issues (other than glasses)		
Recurring sinus infections		
Loss of hearing, ringing in ear		
Seasonal allergies		
Difficulty swallowing		
Respiratory:	Y	N
Recurring shortness of breath		
Frequent cough or wheezing		
Frequent or loud snoring		
Recurring lung infections		
Cardiovascular:	Y	N
Ever had bad chest pain		
High blood pressure		
High cholesterol or lipids		
Gastrointestinal:	Y	N
Recurring abdominal pain		
Recurring nausea, upset stomach		
Indigestion/heartburn		
Irregular bowel movements (normal is 3-14/week without straining)		
Difficulty swallowing; choking episodes		

Musculoskeletal:	Y	N
Frequent joint or bone pain		
Unexplained muscle pain		
Constant urge to move legs		
Leg swelling		
Skin:	Y	N
Recurring rash, itch		
Non-healing lesions, wounds		
Unexplained lumps or bumps		
Endocrine:	Y	N
Recurring irregular periods or cramps		
Excessive thirst, hunger		
Often feel too hot or cold		
Genitourinary:	Y	N
Difficulty starting stream		
Frequent or small voids		
Urinate more than twice per night		
Leaking urine		
Hematologic/Immunologic:	Y	N
History of non-pregnancy anemia		
Ever had blood clot, clotting disorder		
Ever had severe allergic reaction		
Psychiatric:	Y	N
Ever had major depression		
Anxiety, excessive worrying		
Frequent mood swings		
Sexual:	Y	N
Sexually active		
Erectile or vaginal issues		
Poor performance or low sex drive		
Breast or testicular lumps		
Other:		
Other:		