Health History Information

How did you hear of us: ______________________________

Please list the reason you are being seen today: ______________________________

List any drug allergies: ______________________________

____

List all current medications: ______________________________

____

____

Past medical history - Please check any conditions that a doctor has followed you for: ______________________________

High blood pressure	________	High Cholesterol	________
Thyroid Problems	________	Kidney disease	________
Heart Failure	________	Heart Murmur	________
Seizures	________	Stomach Problems	________
Glaucoma	________	Psychiatric Illness	________
Liver Disease	________	Diabetes "sugar"	________
Heart Attack	________	Stroke	________
Intestinal Problems	________	Reflux Disease	________
Arthritis	________	Abnormal Pap	________

Cancer: Type and Location ______________________________

Other: ______________________________

List any hospitalizations or surgeries - including C-section: ______________________________

____

Have you ever had:

Positive Tuberculosis Test: ________

Blood Transfusion: ________

Rheumatic Fever: ________

GREEN OAKS HOSPITAL

7808 Clodus Fields Drive ● Dallas, TX 75251
(972) 991-9504

PATIENT IDENTIFICATION

INTEGRATED OUTPATIENT CLINIC
HEALTH HISTORY INFORMATION

HPS

Preventative Care: When was your last

Tetanus Booster ________ Flu Shot ________ Pneumonia Vaccine ________

Hepatitis Vaccine ________ Colonoscopy / Sigmoidoscopy ________ Bone Densitometry ________

Female Only: How often do you examine your breasts: ________
Do you see an OB/GYN: ________ When was your last Mammogram: ________
When was your last Pap Smear:
Male Only: Do you do a testicular exam: ________
Do you have any problems with erections: ________
When was your last PSA blood test: ________
When was your last Prostate/Rectal exam:

Social Habits:

How many glasses/cups of caffeine do you drink daily: ________

Do you have guns in your home: ________

Do you exercise outside your home: ________

Do you wear a seatbelt: Always Usually Sometimes Never

How do you learn best: - Read it Tell me Show Me

What is your highest level of education: ________

Are you sexually active: ________

1 partner Multiple partners with women with men

Are you a parent: If you are, how many children do you have: ________

Family History: Has anyone in your family ever had any of the following:
This would include Mother, Father, Maternal grandparent, Paternal grandparent or Siblings

High blood pressure: ________

Heart attack or heart surgery: ________

Diabetes: ________

Stroke: ________

Cancer - Type / Location: ________

Osteoporosis: ________

Mental Illness: ________

Glaucoma: ________

Other: ________

Signature ________ Date ________

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