

**NORTH TEXAS INFECTIOUS DISEASES CONSULTANTS, P.A.  
CONFIDENTIAL PATIENT HISTORY**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ M F Today's Date: \_\_\_\_\_  
SEX

<b>Drug Allergies (please list all)</b>	<b>Drug Reaction (e.g., rash, nausea, etc.)</b>

Allergic/Immunologic: (please list all other allergies):  
\_\_\_\_\_

<b>Past Medical History</b> <i>(please check all that apply)</i>	<b>Past Hospitalizations</b>
Blood Disorders <input type="checkbox"/>	<i>Reason for Hospitalization</i> _____ <i>Dates</i> _____
High Blood Pressure <input type="checkbox"/>	_____
Heart Disease <input type="checkbox"/>	_____
Lung Disease <input type="checkbox"/>	_____
Diabetes <input type="checkbox"/>	<b>Past Surgical History</b>
Peptic Ulcer Disease <input type="checkbox"/>	<i>Reason for Surgery</i> _____ <i>Dates</i> _____
Cancer <input type="checkbox"/>	_____
Liver Disease <input type="checkbox"/>	_____
Psychiatric Disorder <input type="checkbox"/>	_____
Other (please list below) <input type="checkbox"/>	_____

<b>Past Transfusions</b>	<i>Date</i>
_____	_____
_____	_____

**Social History**

Marital Status:     Married                       Divorced                       Single

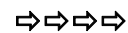
Tobacco Use:       Yes                       No                      How Much? \_\_\_\_\_

Alcohol Use:       Yes                       No                      How Much? \_\_\_\_\_

Drug Use:          Yes                       No                      How Much? \_\_\_\_\_

Occupation: \_\_\_\_\_

**Please complete information on back of this form**



**Family History**

*Please list any significant or serious illnesses in your family:*

**Review of Systems (please circle all which are applicable) :**

**Constitutional:** Weight loss Weight gain Fever Chills Sweats Fatigue Weakness

**Eyes:** Wear glasses Blurry vision Flashing lights Blindness

**Ears, Nose, Mouth:** Ear ache Poor hearing Sore throat

**Cardiovascular:** Chest Pain Palpitations Swelling of feet

**Respiratory:** Shortness of breath Cough Asthma

**Gastrointestinal:** Abdominal pain Nausea Vomiting Diarrhea Constipation Blood in stool

**Genitourinary:** Painful urination Frequent urination Nighttime urination

Problems w/testicles

Abnormal periods

Last normal menstrual period:

\_\_\_\_\_ *DATE*

**Musculoskeletal:** Muscle pain Joint pain

**Skin:** Rash Sores on skin Skin cancer Boils

**Neurological:** Headache Dizziness Seizures Numbness Tingling

**Heme/Lymphatic:** Swollen lymph glands Anemia

**What problem do you have today?** \_\_\_\_\_

**Do you have other symptoms? (please list)** \_\_\_\_\_

**Do you have a Living Will?**

If "Yes", what are the contents?

Yes  No

No Resuscitation

Unaware of Contents

No Feeding Tubes

Other \_\_\_\_\_

No Medication Support

No Mechanical Ventilation

**Do you have a Durable Power of Attorney?**

Yes  No

**Name:** \_\_\_\_\_