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ADULT DATABASE

NAME: _____ DATE OF BIRTH: _____ DATE: _____

AGE: _____ SEX: MALE FEMALE

Why have you come to see the doctor today? _____

YOUR PAST MEDICAL HISTORY

(check all that apply):

- | | | | |
|--|---------------------|---|---------------------|
| | <u>Yr Diagnosed</u> | | <u>Yr Diagnosed</u> |
| <input type="checkbox"/> Heart Disease | _____ | <input type="checkbox"/> Peptic Ulcer | _____ |
| <input type="checkbox"/> Stroke | _____ | <input type="checkbox"/> Gastrointestinal Disorder | _____ |
| <input type="checkbox"/> High Blood Pressure | _____ | <input type="checkbox"/> Head Injury, Seizures | _____ |
| <input type="checkbox"/> Rheumatic Fever | _____ | <input type="checkbox"/> Migraines | _____ |
| <input type="checkbox"/> High Cholesterol levels | _____ | <input type="checkbox"/> Mental Illness | _____ |
| <input type="checkbox"/> Diabetes | _____ | <input type="checkbox"/> Colon Disorder | _____ |
| <input type="checkbox"/> Kidney Disease | _____ | <input type="checkbox"/> Liver, Hepatitis | _____ |
| <input type="checkbox"/> Thyroid or Glandular | _____ | <input type="checkbox"/> Sexually Transmitted Disease
(HIV, Gonorrhea, Etc.) | _____ |
| <input type="checkbox"/> Asthma/ Lung | _____ | <input type="checkbox"/> Other: _____ | |
| <input type="checkbox"/> Cancer | _____ | <input type="checkbox"/> Other: _____ | |
| <input type="checkbox"/> Back or Spine Disorder | _____ | | |

GYN (WOMEN ONLY)

Age Menses began: _____ Date of Last Menstrual Cycle: _____ Birth Control Method using now: _____
 Total # Pregnancies: _____ Full term pregnancies: _____ Living children: _____ Miscarriages: _____ Abortions: _____
 Date of last Pap smear? _____ Ever abnormal Pap? _____ Date of last mammogram? _____
 Do you perform regular monthly self breast exams? _____

VACCINES & CHILDHOOD DISEASES: (Please check all that you have had): Childhood vaccines

- Pneumococcal (pneumonia) vaccine Hepatitis B vaccine Tetanus (most recent year): _____
 Chickenpox (varicella): disease vaccine Other _____

LIST ALL HOSPITALIZATIONS, SURGERIES OR SERIOUS ILLNESS AND GIVE DATES

TYPE	YEAR	TYPE	YEAR
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

REGULAR MEDICATIONS (include vitamins, over the counter, birth control, herbal meds,)

DRUG/ DRUG STRENGTH/ FREQUENCY

(Example: Tagamet, 400mg, one 2 times a day)

- | | |
|----------|-----------|
| 1. _____ | 6. _____ |
| 2. _____ | 7. _____ |
| 3. _____ | 8. _____ |
| 4. _____ | 9. _____ |
| 5. _____ | 10. _____ |
| | 11. _____ |
| | 12. _____ |

Allergies/reactions to medications, food, latex, etc.: _____ None

FAMILY HISTORY

<u>Age</u>	<u>Medical Problems (List) and Cause of Death if Deceased</u>	<u>Deceased?</u>
Father _____	_____	<input type="checkbox"/> @ age _____
Mother _____	_____	<input type="checkbox"/> @ age _____
Brother _____	_____	<input type="checkbox"/> @ age _____
Brother _____	_____	<input type="checkbox"/> @ age _____
Sister _____	_____	<input type="checkbox"/> @ age _____
Sister _____	_____	<input type="checkbox"/> @ age _____
Children _____	_____	<input type="checkbox"/> @ age _____
_____	_____	<input type="checkbox"/> @ age _____

Has any member of your family had (check all that apply):

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Sickle Cell Anemia	<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Cancer	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> High Cholesterol
<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Migraine	<input type="checkbox"/> Asthma/Lung Disease
<input type="checkbox"/> Stomach Ulcer	<input type="checkbox"/> Inheritable Disorder	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Stroke	<input type="checkbox"/> Mental Illness	<input type="checkbox"/> Blood Disease
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Colon Disease	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Alcohol/Drug Abuse	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Gout	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Hepatitis

Please explain any checked above: _____

SOCIAL HISTORY

What is your occupation? _____

Marital Status: Married Separated Divorced Widowed Single

HIV/ Hepatitis risk factors: (check below) (or check here if you do not wish to comment)

Tattoos Homosexual contact IV drug use Multiple sexual partners Blood Transfusion

Tobacco Use History (circle): Never Smoke(d) Dip/Chew(ed)

If **Current** use: (Packs/day: _____ How many years? _____) Movitated to quit? Y N

If **Previous** use: (Quit when? _____ Smoked/Dipped how many years? _____)

Alcohol Use: (circle) No Yes How many drinks/**week**?: _____

Drug use: (circle) No Yes Explain: _____

Diet: Good (low cal, low fat, high fiber). Average They know me by name at McDonalds.

How many caffeinated drinks/ day? _____

Exposure to toxic chemicals: _____

Foreign travel in the past 6 months (Where?): _____

Exercise Routine (**what, how much, & how often**): _____

Major Changes, stresses: _____

Have you signed for organ donation? _____

Do you have a living will? _____ (If not, please ask if you would like us to provide you with one.)

The above is complete and true to the best of my knowledge.

X _____
Patient's Signature

Date