

**TEXAS HEALTH CARE, P.L.L.C.**

1420 8th Avenue, Suite 101  
Fort Worth, TX 76104

label space

Patient Name: \_\_\_\_\_ DOB \_\_\_\_\_

Referred By: \_\_\_\_\_ Other Consultants: \_\_\_\_\_

Chief Complaint: \_\_\_\_\_

HISTORY OF PRESENT ILLNESS		ALLERGIES	
MEDICAL HISTORY		SOCIAL HISTORY	
Diabetes ..... Yes No _____	High Blood Pressure ..... Yes No _____	Married _____	Single _____
Cancer ..... Yes No _____	Stroke ..... Yes No _____	Widowed _____	Divorced _____
Heart Trouble ..... Yes No _____	Heart Trouble ..... Yes No _____	Separated _____	Occupation _____
Arthritis / Gout ..... Yes No _____	Arthritis / Gout ..... Yes No _____	<b>Tobacco Use:</b> _____	Never _____
Lung Problems ..... Yes No _____	Lung Problems ..... Yes No _____	Previously, but quit _____	Packs / Year _____
Bleeding Tendency. .... Yes No _____	Bleeding Tendency. .... Yes No _____	<b>Alcohol Use:</b> _____	Never _____
Acute Infections ..... Yes No _____	Acute Infections ..... Yes No _____	Rarely _____	Moderate _____
Venereal Disease ..... Yes No _____	Venereal Disease ..... Yes No _____	Daily _____	Quit _____
Other ..... Yes No _____	Other ..... Yes No _____		
LMP ..... Yes No _____	LMP ..... Yes No _____		
PRIOR SURGERY OR TRAUMA HISTORY		MEDICATIONS	
Year			
FAMILY HISTORY		HERBS	
Diabetes ..... Yes No _____	High Blood Pressure ..... Yes No _____		
Cancer ..... Yes No _____	Stroke ..... Yes No _____		
Heart Trouble ..... Yes No _____	Heart Trouble ..... Yes No _____		

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_