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

Diabetes ..... Yes No _____
High Blood Pressure ..... Yes No _____
Cancer ..... Yes No _____
Stroke ..... Yes No _____
Heart Trouble ..... Yes No _____
Arthritis / Gout ..... Yes No _____
Lung Problems ..... Yes No _____
Bleeding Tendency. ..... Yes No _____
Acute Infections ..... Yes No _____
Venereal Disease ..... Yes No _____
Other ..... Yes No _____
LMP ..... Yes No _____

SOCIAL HISTORY

Married _____
Single _____
Widowed _____
Divorced _____
Separated _____
Occupation _____
Tobacco Use: _____
Never _____
Previously, but quit _____
Packs / Year _____
Alcohol Use:
Never _____
Rarely _____
Moderate _____
Daily _____
Quit _____

PRIOR SURGERY OR TRAUMA HISTORY

Year

MEDICATIONS

FAMILY HISTORY

Diabetes ..... Yes No _____
High Blood Pressure ..... Yes No _____
Cancer ..... Yes No _____
Stroke ..... Yes No _____
Heart Trouble ..... Yes No _____

HERBS

Patient's Signature _____ *Date* _____