

Chief Complaint/Reason for Visit: _____

Transportation Home: Name of Driver: _____ Telephone #: _____

Do you have any cultural/religious practices that will impact your health care decision? No Yes Explain: _____

Do you have a living will? No Yes Advance directives? No Yes

(To be completed by patient, family member, or responsible party. Please review and mark any problems you may have now, or have had in the past.)

<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Fainting	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Heart Surgery	<input type="checkbox"/> Seizure Disorder	<input type="checkbox"/> Back Injury	<input type="checkbox"/> Cataracts	<input type="checkbox"/> Motion Sickness
<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Neck Injury	<input type="checkbox"/> Anemia	<input type="checkbox"/> TMJ
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Leg Cramps or Pain	<input type="checkbox"/> Herniated Disc	<input type="checkbox"/> Vision Disorder	<input type="checkbox"/> Neck Pain / Stiffness
<input type="checkbox"/> Irregular Heartbeats	<input type="checkbox"/> Blood Clots	<input type="checkbox"/> Steroid Use	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> False Teeth / Caps
<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Varicose Veins	<input type="checkbox"/> Ulcer	<input type="checkbox"/> TB	<input type="checkbox"/> Loose/ Chipped Tooth
<input type="checkbox"/> Stroke	<input type="checkbox"/> Chemical Dependency	<input type="checkbox"/> Frequent Heartburn	<input type="checkbox"/> Sinusitis	<input type="checkbox"/> Kidney Disease / Stone
<input type="checkbox"/> Easy Bruising	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hiatal Hernia	<input type="checkbox"/> Recent Cold/	<input type="checkbox"/> Bladder Problems
<input type="checkbox"/> Hemophilia	<input type="checkbox"/> HIV	<input type="checkbox"/> Cancer	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Prostate Problems
<input type="checkbox"/> Bleeding Tendency	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Hoarseness
<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Radiotherapy	<input type="checkbox"/> Asthma	<input type="checkbox"/> Sex. Trans. Disease
<input type="checkbox"/> Mental Illness	<input type="checkbox"/> Autoimmune Disease	<input type="checkbox"/> Prosthesis	<input type="checkbox"/> Chronic Cough	<input type="checkbox"/> Multiple Sclerosis
<input type="checkbox"/> Migraine Headache	<input type="checkbox"/> Frequent Wound Infection		<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Sleep Apnea

Tobacco: No Yes Amount _____ Packs /day for _____ years.
 Alcohol: No Yes Amount _____
 Street/Recreational Drug? Use No Yes Types: _____
 Could you be pregnant? No Yes N/A
 Start date of last menstrual period: ____ / ____ / ____ N/A
 Height _____ Weight _____

List any medical problems not listed above:

List all previous surgeries & hospitalizations:

Current Medications

(include over-the-counter medications, vitamins, herbs)

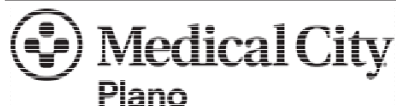
NAME	DOSE	SCHEDULE	LAST TAKEN
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			

Implants (Surgical/Cosmetic)? No Yes If yes, what type?

Problems with Anesthesia? No Yes Explain: _____

Allergies (include medications, foods, environment, tape, latex, dyes below.) NO KNOWN ALLERGIES

NAME	REACTION
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	



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Outpatient Services Patient Questionnaire



PATIENT IDENTIFICATION