TEXAS HEALTH CARE, P.L.L.C.
75 Main Street, Suite 150
Colleyville, TX 76034

Patient Name: _____ DOB _____

How Did You Hear About Us?: _____

Chief Complaint: _____ Other Consultants: _____

HISTORY OF CHIEF COMPLAINT

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 _____
LMP ..... _____
Other ..... _____

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* _____

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PATIENT HISTORY/REVIEW OF SYSTEMS

HAVE YOU OR ARE YOU BEING TREATED FOR: please check or circle all that apply			
	Diabetes		**GENITOURINARY**
	Hypertension		Frequent urination
	Cancer		Burning or painful urination
	Stroke		Blood in urine
	Heart Trouble		Change in force or strain when urinating
	Arthritis/gout		Incontinence or dribbling
	CONSTITUTIONAL SYMPTOMS		Kidney stones
	Good general health		Ejaculation problems
	Recent weight change		Nocturia
	Fever		Male - Testicle Pain
	Fatigue		Number of pregnancies
	Headaches		Number of miscarriages
	EYES		**MUSCULOSKELETAL**
	Eye disease or injury		Joint pain
	Wear glasses or contacts		Joint stiffness or swelling
	Blurred or double vision		Weakness of muscles or joints
	Glaucoma		Muscle pain or cramps
	EAR/NOSE/MOUTH/THROAT		Cold extremities
	Hearing loss or ringing		Difficulty in walking
	Earaches or drainage		**INTEGUMENTARY (skin/breast)**
	Chronic sinus problem or rhinitis		Rash or itching
	Nose bleeds		Change in skin color
	Mouth sores		Change in hair or nails
	Bleeding gums		Varicose veins
	Bad breath or bad taste		Breast pain / lump / discharge
	Sore throat or voice change		**NEUROLOGICAL**
	Swollen glands in neck		Frequent or recurring headaches
	CARDIOVASCULAR		Light headed or dizzy
	Heart trouble		Convulsions or seizures
	Chest pain or angina pectoris		Numbness or tingling sensations
	Palpitation		Tremors
	Shortness of breath with walking or lying flat		Paralysis
	Swelling of feet, ankles, or hands		Stroke
	RESPIRATORY		Head injury
	Chronic or frequent coughs		**PSYCHIATRIC**
	Spitting up blood		Memory loss or confusion
	Shortness of breath		Nervousness
	Asthma or wheezing		Depression
	GASTROINTESTINAL		Insomnia
	Loss of appetite		Psychosis
	Change in bowel movements		**ENDOCRINE**
	Nausea or vomiting		Glandular problems
	Frequent diarrhea		Hormone problems
	Painful bowel movements or constipation		Excessive thirst
	Rectal bleeding or blood in stool		Tired / Sluggish
	Abdominal pain or heartburn		Diabetes
	Peptic Ulcer		**HEMTALOGIC / LYMPHATIC**
	Convulsions		Slow to heal after cut
	Bleeding tendency		Anemia
	Acute Infections		Phlebitis
	Venereal disease		Past blood transfusion
	Hereditary defects		Swollen glands

Patient's Signature _____ Date _____ Physician's Initials _____ Date _____

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PHOTO CONSENT

Medical photographs/slides and videotapes may be taken before, during, or after a surgical procedure or treatment. Consent is required to take such images.

Additionally, patients may consent to release these medical photography/slides, and videotapes for a stated purpose.

I hereby authorize Texas Health Care, P.L.L.C physicians and associates or licensees to take pre-operative, intra-operative, and post-operative photographs, slides, and/or videotapes. I also authorize Texas Health Care, P.L.L.C physicians and associates or licensees to use pre-operative, intra-operative, and post-operative photographs, slides, and/or videotapes for professional medical purposes deemed appropriate, including but not limited, to showing these images on public or commercial television, electronic digital networks, for purposes of medical education, patient education, lay publication, professional publication or during lecturers to medical or lay groups.

I understand that I will not be entitled to monetary payment or any other consideration as a result of any use of these images and/or my interview.

DATE: _____

PATIENT SIGNATURE: _____