UT Health San Antonio

PATIENT HISTORY FORM

DATE _____

NAME _____ _____ _____

LAST **FIRST** **M.I.** **DATE OF BIRTH** **AGE**

Who may we thank for referring you to our practice? _____

PRIMARY CARE PHYSICIAN (PCP)

Name of PCP _____ Office Tel# _____

Address _____

PHARMACY

Name _____ Phone# _____

Address _____

SOCIAL HISTORY

Tobacco Use: ____ Yes ____No If yes, ____ number of packs per day. How many years? _____

If you currently do not use tobacco but did in the past, when did you stop? _____

Alcohol Use: ___ Yes ____ No If yes how much? _____

FAMILY HISTORY: next to the line please make the condition/disease that your family member has. Mother (M), Father (F), Brother (B), Sister (S), Maternal Grandmother or Grandfather (MGM, MGF), Paternal Grandmother or Grandfather (PGM, PGF), Maternal Aunt or Uncle (MA, MU), Paternal Aunt or Uncle (PA, PU).

__ Alcoholism __ Breast Cancer __ Diabetes __ Aneurysm __ Stroke

__ Anemia __ Cancer __ Heart Attack __ Renal Failure __ Varicose Veins

__ Bleeds Easily __ Blood Clots __ Hepatitis __ Seizures __ High Blood Pressure

PLEASE PLACE AN X BY THE AILMENT THAT APPLIES TO YOU. IF UNSURE, PLACE A QUESTION MARK (?)

__ Alcoholism __ Breast Cancer __ Diabetes __ Aneurysm __ Stroke

__ Anemia __ Cancer __ Heart Attack __ Renal Failure __ Varicose Veins

__ Bleeds Easily __ Blood Clots __ Hepatitis __ Seizures __ High Blood Pressure

UT Health San Antonio

PATIENT HISTORY FORM

DATE _____

NAME _____ _____

LAST **FIRST** **M.I.** **DATE OF BIRTH**

LIST ALL DRUG ALLERGIES IF NONE WRITE: NKDA		

LIST ALL MEDICATION YOU ARE TAKING NOW, INCLUDING HERBAL MEDICATIONS		
NAME OF MEDICATION	**DOSE AMOUNT**	**FREQUENCY**

SURGICAL / HOSPITALIZATION HISTORY			
DATE		**DATE**	

UT Health San Antonio

PATIENT HISTORY FORM

REVIEW OF SYSTEMS

DATE _____

NAME _____ _____

LAST **FIRST** **M.I.** **DATE OF BIRTH**

*PLEASE CHECK YES OR NO BY THE CURRENT COMPLAINTOR AILMENT THAT APPLIES TO **YOU**. IF UNSURE, PLACE A QUESTION MARK (?)*

GENERAL

YES NO

___ ___ Weight Loss Greater than 10 lbs In last year
___ ___ Poor Appetite
___ ___ Trouble Sleeping
___ ___ Fever

EYES

___ ___ Glasses
___ ___ Loss or Change of Vision
___ ___ Glaucoma or Cataracts

EARS, NOSE, AND THROAT

___ ___ Hearing Aids/ Hearing Loss
___ ___ Sore Throat/ Strep Throat
___ ___ Nose Bleeds
___ ___ Recurrent Ear Infections

CARDIOVASCULAR

___ ___ High Blood Pressure
___ ___ Heart Murmur
___ ___ Mitral Valve Prolapse
___ ___ Irregular Heartbeat
___ ___ Previous Heart Attack
___ ___ Chest Pain
___ ___ Deep Vein Thrombosis (DVT)

RESPIRATORY

___ ___ Shortness of Breath
___ ___ Asthma
If Yes, # of times inhaler is used in week? ____
___ ___ History of Tuberculosis
___ ___ Chronic Cough
___ ___ Emphysema
___ ___ COPD (Chronic Obstruction Pulmonary Disease)

GASTROINTESTINAL

___ ___ Ulcers
___ ___ Nausea/ Vomiting
___ ___ Hemorrhoids
___ ___ Jaundice
___ ___ Cirrhosis
___ ___ Gallstones

GENITOURINARY

YES NO

___ ___ Problems Urinating
___ ___ Difficulty Starting Stream
___ ___ Painful/Burning/Frequent Urination
___ ___ Dialysis

MUSCULOSKELETAL

___ ___ Abnormal Growths/ Lumps
___ ___ Joint Swelling or Pain
___ ___ Amputation
What Part?_____

SKIN

___ ___ Psoriasis
___ ___ Non-Healing, Crusting of Skin
___ ___ Skin Cancer
If so, Where?_____

NUERO

___ ___ Blackouts/ Fainting
___ ___ Seizures
___ ___ Headaches
___ ___ Problems with Speech
___ ___ Confusion

PSYCHIATRIC

___ ___ Prior Counseling
___ ___ Taking Medication for Pysch Problems
___ ___ Severe Depression

ENDOCRINE

___ ___ Diabetes
___ ___ Thyroid Problems

ALLERGY/IMMUNOLOGIC

___ ___ Food Allergies
___ ___ HIV Infection
___ ___ Hepatitis ___ A, ___ B, ___ C

HEMATOLGOIC/ LYMPHATIC

___ ___ Bleeding Disorders
___ ___ Enlarged Lymph Nodes

VASCULAR

___ ___ Non Healing Wound

The University of Texas Health San Antonio

CONSENT FOR PHOTOGRAPHY

Patient Name _____ DOB _____

Parent or Legal Guardian _____

I consent to have my photo image to be taken by the staff at ***UT Health Surgery Specialties Group as*** described below.

I understand that my photographs, videotapes, digital, and other images may be recorded to document and assist with my care and the payment of my (or child or an individual to whom I provide guardianship). These images may be used to assist in the education of students and residents within the institution. I understand that The University of Texas Health Science Center at San Antonio will own these images, but that I will be allowed access to view them or to obtain copies of them at a reasonable cost. Other than treatment, education, and payment purposes, images that identify me (or child or an individual to whom I provide guardianship) will not be released and/or used outside the organization only upon written authorization from me or the patient representative.

If the images are to be taken for any purpose other than for treatment, education, or payment purposes, the purpose(s) must be stated:

_____

_____

I may revoke or withdraw this consent at any time. Such withdrawal of consent must be made in writing. Withdrawal of consent does not affect any information disclosed prior to the written notice of withdrawal.

I release and hold harmless The University of Texas Health Science Center at San Antonio, the UT Medicine of San Antonio, its staff and employees from any and all claims or causes of action that I may have of any nature whatsoever, which may in any manner result from the use of the photograph or other image.

By signing below, I am indicating that I have read and understand the "Consent for Photography" form. I am either the patient or have the authority to give consent for the patient. My questions regarding this consent have been answered.

_____ _____

(Patient or Patient Representative Signature) Date

_____ _____

Print Name If Patient Representative, Relationship to Patient