CapitalMedicalClinic

Serving Austin since 1934

New Patient Evaluation

Name: _____ Date of Exam: _____

Referred by: _____ Date of Birth: _____

Reason for your visit:

Please list your chief complaints or concerns:
(*Please limit these to 2-3 per visit so that we can provide adequate attention to each issue*.)

1. _____

2. _____

3. _____

Specialists

Name of Specialist	Type of Specialty

Past Medical History:

1. Medications (All medications you are currently taking, including over the counter)

Name	Dosage (Milligrams)	Times per day
a.		
b.		
c.		
d.		

e. _____

f. _____

g. _____

2. Medication Allergies

Medication:	Reaction:
a. _____	
b. _____	
c. _____	

3. Operations

Operations	Date of Operations:
a. _____	
b. _____	
c. _____	
d. _____	
e. _____	
f. _____	

4. Please list all previous illnesses (e.g. diabetes, hypertension, hospitalizations)

Illness	Date of Diagnosis
a. _____	
b. _____	
c. _____	
d. _____	
e. _____	
f. _____	
g. _____	

h. _____

i. _____

j. _____

Family History

Circle	Illnesses	Age at Illness Diagnosis
Mother ○ Living/Deceased ○ (Age___)	a.	
	b.	
	c.	
Father ○ Living/Deceased ○ (Age___)	a.	
	b.	
	c.	
Sibling ○ Living/Deceased ○ ○ Sister/Brother ○ (Age___)	a.	
	b.	
Sibling ○ Living/Deceased ○ ○ Sister/Brother ○ (Age___)	a.	
	b.	
Sibling ○ Living/Deceased ○ ○ Sister/Brother ○ (Age___)	a.	
	b.	

Social History

1. Spousal Status (Please circle): ○ Married ○ Partnered ○ Single ○ Widowed

2. Living Arrangement (Please circle): ○ Live alone ○ Live with other(s)
   Live with whom?_____

3. Children: ○ Yes/No ○ Number of Children Ages of Children

   _____

4. Occupation: _____

5. Exercise: # of days per week How long per session? Type of Exercise

_____

6. Hobbies (How do you spend your free time?)

_____

7. Do you smoke tobacco now? ○ Yes or No ○ Packs/Day # of Years

_____

Have you ever smoked tobacco? ○ Yes or No ○ _____

What year did you quit smoking tobacco? _____

8. Do you drink alcohol? ○ Yes or No ○ Beverages per day per week

_____

9. Have you ever used recreational drugs? ○ Yes or No ○

If yes, which drugs? _____

10. Have you recently traveled out of the country? ○ Yes or No ○

If yes, where? _____

Review of Systems:

Please circle if you have had recently had problems with any of the following:

General:

Weight Gain (How much? _____ Over how long? _____)
Weight Loss (How much? _____ Over how long? _____)

□ Fatigue □ Fever □ Night sweats □ Heat or cold intolerance

Skin

□ Rash □ Hair loss □ Easy bruising □ Toenail infection

Eyes

□ Redness □ Pain □ Discharge □ Dryness □ Visual changes

Nose

□ Nose bleed □ Nasal discharge/drainage □ Sinus pain □ Sinus congestion

Mouth

☐ Oral lesions ☐ White patches ☐ Bleeding gums ☐ Toothache

Throat

☐ Hoarseness ☐ Sore Throat ☐ Pain with swallowing ☐ Difficulty swallowing

Respiratory

☐ Cough ☐ Coughing blood ☐ Shortness of breath at rest
☐ Shortness of breath on exertion ☐ Wheezing

Cardiovascular

☐ Chest discomfort ☐ Palpitations (Heart fluttering or racing)
☐ Ankle swelling ☐ Fast heart beat
☐ Difficulty breathing when lying down ☐ Awakening short of breath

Urinary

☐ Pain with urination ☐ Urinating frequently
☐ Incontinence (losing your urine) with coughing/laughing
☐ Urinating before you can get to the bathroom
☐ Urination at night ☐ Difficulty starting a urine stream ☐ Blood in urine

Gastrointestinal

☐ Nausea/Vomiting ☐ Diarrhea ☐ Blood in the stool
☐ Black, tarry stool ☐ Heartburn/Reflux ☐ Constipation

Sexual

☐ Difficulty achieving and maintaining an erection ☐ Decreased libido

Musculoskeletal

☐ Joint pain or stiffness: Which joints? _____
☐ Joint swelling or redness Which joints? _____
☐ Back pain ☐ Muscle pain

Neurological

☐ Difficulty with memory ☐ Fainting/Losing consciousness
☐ Weakness: Which part of your body? _____
☐ Seizures ☐ Severe or frequent headaches ☐ Difficulty with balance
☐ Difficulty walking ☐ Lightheadedness ☐ Vertigo (world spinning around you)

Psychological

☐ Depression
☐ Lack of interest in and enjoyment of activities that used to bring pleasure/fulfillment
☐ Decreased sense of self-worth ☐ Difficulty focusing and concentrating
☐ Desire to end your life ☐ Disabling anxiety ☐ Panic attacks

Sleep

☐ Difficulty getting to sleep ☐ Difficulty staying asleep
☐ Snoring ☐ Cessation of breathing during sleep (as reported by bed partner)

Health Maintenance/Yearly Physical Sheet Date _____

Cholesterol
Most recent cholesterol Date Total Cholesterol LDL HDL Triglycerides

_____

Vaccines
When did you last receive a Tetanus vaccine booster? _____

Have you received the Shingles vaccine? Yes or No or Not sure

Have you received the Pneumovax (pneumonia vaccine)? Yes or No or Not sure If yes, when?_____

Have you received the Flu Vaccine this flu season? Yes or No

Colon Cancer Screening
Have you had a colonoscopy? _____

If have had a colonoscopy, when did you last have it done? _____

Was your colonoscopy normal? _____

If it was abnormal, what was found? _____

Bone density
Have you had a bone density test? Yes or No or Not Sure

If yes, when did you last have it done? _____

For women:
When was your last mammogram? _____

Have you had a hysterectomy? Yes or No When? Why?

_____

When was your last pap smear? _____

Have you ever had an abnormal pap smear? Yes or No When? _____

For men:
When did you have your last digital rectal exam and PSA checked? _____

Skin
Have you had a skin cancer screening check by a dermatologist? Yes or No If yes, when?_____