CapitalMedicalClinic
Serving Austin since 1934

NEW PATIENT HISTORY

NAME

DATE OF VISIT

REFERRED BY

DATE OF BIRTH

PREFERRED PHARMACY/LOCATION/PHONE #

MAIL ORDER PHARMACY

LIST MEDICATION ALLERGIES REACTION

REASON FOR VISIT

REASON #1

REASON #2

REASON #3

CURRENT MEDICATIONS

NAME	DOSAGE	TIMES PER DAY

MEDICAL HISTORY

DIAGNOSIS:	DIAGNOSIS:	DIAGNOSIS:
HIGH BLOOD PRESSURE ☐	ACID REFLUX ☐	HEART DISEASE ☐
DIABETES ☐	OSTEOPOROSIS ☐	HEART ATTACK @AGE ☐
HIGH CHOLESTEROL ☐	ANXIETY ☐	DEPRESSION ☐
ASTHMA ☐	THYROID DISEASE ☐	STROKE ☐
SLEEP APNEA ☐	ALLERGIES ☐	CANCER ☐
HEART MURMUR OTHER ☐	COPD ☐	CANCER TYPE: ☐

MEDICAL ISSUES?

PREVIOUS SURGERIES

LIST YEAR FOR EACH SURGERY

SPECIALISTS

FAMILY HISTORY

RELATIONSHIP	AGE	LIVING	DECEASED	HEART DISEASE	HIGH CHOLESTEROL	DIABETES	THYROID DISEASE	OSTEOPOROSIS	STROKE	CANCER	HIGH BLOOD PRESSURE	DEPRESSION /ANXIETY	OTHER
MOTHER													
FATHER													
SIBLING Choose Sibling													
SIBLING Choose Sibling													
SIBLING Choose Sibling													
SIBLING Choose Sibling													

OTHER SIGNIFICANT FAMILY HISTORY:

SPOUSAL STATUS

☐ MARRIED ☐ PARTNER ☐ SINGLE ☐ DIVORCED ☐ WIDOWED

SOCIAL HISTORY

OCCUPATION:

LIVING ARRANGEMENT: FRIENDS/FAMILY ☐ LIVING ALONE ☐ ASSISTED LIVING ☐ RETIREMENT COMMUNITY ☐

LIVING WITH FACILITY NAME

NUMBER OF CHILDREN NUMBER OF LIVING CHILDREN

EXERCISE: NUMBER OF DAYS PER WEEK DURATION TYPES

HOBBIES:

DO YOU CURRENTLY SMOKE? YES ☐ NO ☐ PACKS PER DAY # OF YEARS YEAR YOU QUIT

CIGARETTES ☐ CIGARS ☐ PIPE ☐ HAVE YOU EVER SMOKED? YES ☐ NO ☐

DO YOU USE SMOKELESS TOBACCO? YES ☐ NO ☐ VAPE / E-CIGS ☐

DO YOU DRINK ALCOHOL? YES ☐ NO ☐ ☐ # OF DRINKS ☐ PER DAY ☐ PER MONTH ☐ PER YEAR

HAVE YOU EVER USED RECREATIONAL DRUGS? YES ☐ NO ☐ IF YES, PLEASE LIST

HAVE YOU RECENTLY TRAVELED OUTSIDE OF THE COUNTRY? YES ☐ NO ☐ IF YES, PLEASE LIST

REVIEW OF SYSTEMS

PLEASE CHECK 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?

SKIN: RASH ☐ HAIR LOSS ☐ EASY BRUISING ☐

EYES: REDNESS ☐ PAIN ☐ DRYNESS ☐ DISCHARGE ☐ VISUAL CHANGES ☐

NOSE: NOSE BLEED ☐ SINUS PAIN ☐ SINUS CONGESTION ☐ NASAL DISCHARGE/ DRAINAGE ☐

THROAT: SORE THROAT ☐ HOARSENESS ☐ DIFFICULTY SWALLOWING ☐

RESPIRATORY: COUGH ☐ COUGHING BLOOD ☐ SHORT BREATH: @ REST ☐ W/ EXERTION ☐ WHEEZING ☐

CARDIOVASCULAR: CHEST DISCOMFORT ☐ PALPITATIONS (HEART FLUTTER OR RACING) ☐ FAST HEART RATE ☐

DIFFICULTY BREATHING WHILE LYING DOWN ☐ SHORT BREATH AFTER WAKING ☐ ANKLE SWELLING ☐

URINARY: URINATING FREQUENTLY ☐ DIFFICULT TO BEGIN URINATING ☐ PAIN WITH URINATION ☐

INCONTINENCE WHILE LAUGHING/ COUGHING ☐ URINATING BEFORE REACHING TOILET ☐

GASTROINTESTINAL: NAUSEA / VOMITING ☐ HEARTBURN/REFLUX ☐ DIARRHEA ☐ CONSTIPATION ☐

BLOOD IN STOOL ☐ BLACK, TARRY STOOL ☐

MUSCULOSKELETAL: JOINT SWELLING / REDNESS ☐ MUSCLE PAIN ☐ BACK PAIN ☐ JOINT PAIN/STIFFNESS ☐

LOCATION: LOCATION:

REVIEW OF SYSTEMS (CONTINUED)

NEUROLOGICAL: DIFFICULTY WITH MEMORY ☐ FAINTING / LOSING CONSCIOUSNESS ☐ DIFFICULTY WALKING ☐
SEIZURES ☐ SEVERE / FREQUENT HEADACHES ☐ LIGHTHEADEDNESS ☐ DIFFICULT TO BALANCE / VERTIGO ☐

PSYCHOLOGICAL: DEPRESSION ☐ DIFFICULTY WITH FOCUS/ CONCENTRATION ☐ LOSS OF INTEREST ☐
DECREASED SENSE OF SELF WORTH ☐ DESIRE TO END YOUR LIFE / SUICIDAL THOUGHTS ☐ PANIC ATTACKS ☐
DISABLING ANXIETY ☐

SLEEP: DIFFICULTY GOING TO SLEEP ☐ DIFFICULTY STAYING ASLEEP ☐ SNORING ☐
CESSATION OF BREATHING DURING SLEEP AS REPORTED BY YOUR PARTNER ☐

HEALTH MAINTENANCE / PREVENTATIVE SCREENINGS

IMMUNIZATIONS HISTORY:

TETANUS (TD/TDAP)? YES ☐ NO ☐ NOT SURE ☐ DATE: ☐

SHINGLES VACCINE? YES ☐ NO ☐ NOT SURE ☐ SHINGRIX? DATE1: ☐ DATE2: ☐
ZOSTAVAX? DATE: ☐

PNEUMONIA VACCINE? YES ☐ NO ☐ NOT SURE ☐ PNEUMOVAX? DATE: ☐

FLU VACCINE THIS SEASON? YES ☐ NO ☐ PREVNAR? DATE: ☐

COLONOSCOPY? YES ☐ NO ☐ NOT SURE ☐ RESULT & DATE: ☐

BONE DENSITY? YES ☐ NO ☐ NOT SURE ☐ RESULT & DATE: ☐

EYE EXAM? YES ☐ NO ☐ RESULT & DATE: ☐

HAVE YOU HAD A SKIN CANCER SCREENING CHECK FROM A DERMATOLOGIST? YES ☐ NO ☐ DATE: ☐

FOR WOMEN:

LAST MAMMOGRAM? RESULT & DATE: ☐

LAST PAP SMEAR? RESULT & DATE: ☐

HAVE YOU EVER HAD AN ABNORMAL PAP SMEAR? YES ☐ NO ☐ REASON & DATE: ☐

HAVE YOU HAD A HYSTERECTOMY? YES ☐ NO ☐ REASON & DATE: ☐

FOR MEN:

WHEN DID YOU HAVE YOUR LAST DIGITAL RECTAL EXAM OR PSA CHECKED? DATE: ☐