PARK CITIES PERSONAL PHYSICIANS
SARAH B. DAVIS MD

Today's Date:_____

Name: _____
Age: _____ Birthdate:_____

MEDICAL HISTORY

Please list current or recent medical conditions:_____
_____
_____
_____
_____
_____

Please check other conditions you have had in the past:

__AIDS or HIV
__Anemia
__Asthma
__Cancer
__Chemical Dependency
__Diabetes
__Epilepsy or Seizures
__Gout
__Hepatitis
__High Cholesterol
__Liver Disease
__Pacemaker
__Stroke
__Thyroid problems
__Venereal Diseases (STD's such as gonorrhea, herpes, genital warts)
__Alcoholism
__Arthritis
__Bulimia/anorexia
__Cataracts
__Depression
__Emphysema
__Glaucoma
__Heart Problems
__High Blood Pressure
__Kidney Disease
__Migraine Headache
__Prostate problems
__Suicide Attempt
__Ulcers
__Others

Have you ever received a blood transfusion?_____When_____

SURGERIES AND HOSPITALIZATIONS

Years **Hospital** **Reason for Hospitalization**

_____
_____
_____
_____
_____
_____
_____
_____
_____

MEDICATIONS **DOSE**

_____
_____
_____
_____
_____
_____
_____
_____

HEALTH MAINTENANCE

When was your last?
Physical exam by MD_____
Pap smear_____**Results**_____
Mammogram_____**Results**_____
Flu Shot_____
Pneumovax_____
Tetanus shot_____
Exercise treadmill test_____**Results**_____
Colonoscopy or Flex sig_____**Results**_____

SOCIAL HISTORY

Substanced used **How much do you use and for how long (If you have Quit list date and how long you used substance.**

__Tobacco _____
__Alcohol _____
__Drugs _____
__Caffeine _____
__Other _____

FAMILY HISTORY

Diseases	Relationship to you
__Asthma	_____
__Cancer	_____
__Heart Attack	_____
__Heart Disease	_____
__High Blood Pressure	_____
__High Cholesterol	_____
__Depression	_____
__Diabetes	_____
__Emphysema	_____
__Kidney Disease	_____
__Stroke	_____
__Tuberculosis	_____
__Other	_____

SYMPTOMS

General

__Chills
__Depression
__Fainting
__Fever
__Headache
__Difficulty sleeping
__Weight change
__Nervousness
__Sweats

Gastrointestinal

__Appetite poor
__Constipation
__Diarrhea
__Indigestion
__Nausea
__Rectal bleeding
__Stomach pain
__Vomiting
__Vomiting Blood

Eye, Ear, Nose, Throat

__Blurred vision
__Difficulty swallowing
__Double vision
__Earache
__Ear discharge
__Hoarseness
__Loss of hearing
__Nosebleeds
__Persistent cough
__Ringing in ears
__Sinus problems

Muscles/Joints/Bones
Pain, weakness or numbness

__Arms
__Back
__Feet
__Hands
__Hips
__Legs
__Neck
__Shoulders

Cardiovascular

__Chest Pain
__High Blood Pressure
__Irregular Heart Beat
__Low Blood Pressure
__Poor Circulation
__Rapid Heart Beat
__Swelling of ankles/feet
__Shortness of breath

Skin

__Bruises easily
__Hives
__Change in Moles
__Rash
__Sores that won't heal

Men Only
__Breast lump
__Erection Difficulties
__Lump in testicles
__Sores on penis
__Other

Women only
__Abnormal Pap smear
__Bleeding between periods
__Breast lump
__Extreme Menstrual Pain
__Hot Flashes
__Nipple Discharge
__Pain with intercourse
__Vaginal discharge
What do you use for birth control?_____
Date of last menstrual period_____
Do you go to an OB/GYN? _____
Are you pregnant?_____

I certify that the above information is correct to the best of my knowledge. I will not hold the doctor or any of his/her staff responsible for errors or omissions in the completion of this form.

Signature_____Date_____

Received by_____Date_____