FULL NAME:

DATE OF BIRTH:

DATE:

Thank you for choosing North Dallas Primary Care Doctors. We appreciate your assistance by completing this form, as it will help us better care for you.

Were you referred by another physician? If so, who?

Reason for visit:

Allergies:

List any significant reactions to food/meds ☐ **No known allergies**

Allergy	Reaction

Medications:

List any medications you take, prescription and nonprescription and their dosage: ☐ **No medications**

Medication	Dose	Refill needed Y/N

Local Pharmacy: **Phone Number:**

Address: **City:**

Mail order Pharmacy:

Your Care Team: Please provide the names of any other providers that you currently receive care from.

Past Medical History: Please check all that apply. ☐ No medical problems

	Abnormal pap smear
	Anemia
	Anxiety
	Asthma
	Atrial fibrillation
	Breast cancer
	Cervical cancer
	Chicken pox
	Chronic Back pain
	Colon cancer

	Deep Vein Thrombosis
	Depression
	GERD
	Gestational Diabetes
	GI bleed
	Gout
	Hepatitis A
	Hepatitis B
	Hepatitis C
	Hypertension

	Hyperthyroidism
	Hypothyroidism
	Kidney Stone
	Heart attack
	Kidney Disease
	Kidney Failure
	Seizures
	Skin Cancer
	Stroke
	Substance Abuse
	Ulcers

Additional History:

Past Surgical history:

☐ **No surgical history**

	Abdominal aneurysm
	Appendectomy
	Back Surgery
	Bariatric Surgery
	Brain Surgery
	Breast Biopsy R/L
	Breast Enhancement
	Breast Surgery R/L
	CABG-Heart bypass
	Cardiac catheterization
	Carotid Endarterectomy
	Carpal Tunnel surgery R/L

	Cataract Surgery R/L
	Cerebral Aneurysm
	Colon Surgery
	Gall Bladder removal
	Heart Transplant
	Hip Surgery R/L
	Hysterectomy
	Hysterectomy with ovaries removed
	Kidney removal R/L
	Kidney Transplant
	Knee arthroscopy
	Knee Surgery R/L

	Liver Transplant
	Lung Transplant
	Mastectomy (breast removal) R/L
	Neck Surgery
	Previous C-section
	Shoulder Surgery R/L
	Sinus Surgery
	Tonsillectomy
	Tubal ligation (tubes tied)
	Valve replacement
	Other

Family History:

Please check all that apply:

☐ **No Family history**

	none	Alcohol abuse	Alzheimer's	Asthma	Autoimmune	Breast cancer	Cancer	Colon cancer	COPD/Bronchitis	Depression	Diabetes	Heart Disease	Hyperlipidemia	Hypertension	Lung Cancer	Melanoma	Osteoporosis	Ovarian Cancer	Prostate Cancer	Seizures	Stroke	Thyroid Disease
Mother																						
Father																						
Sister																						
Brother																						
Daughter																						
Son																						
Mat GM																						
Mat GF																						
Pat GM																						
Pat GF																						
Other:																						

Social History:

Alcohol Use: ☐ **Yes** ☐ **No**

Number of drinks/week: _____ glasses of wine _____ cans of beer _____shots of liquor

Sexually Active: ☐ **Yes** ☐ **not currently** ☐ **Never**

Type of birth control: Partners: ☐ **Female** ☐ **Male** ☐ **Both**

Drug Use: ☐ **Yes** ☐ **No** **Former Type of Drugs: _____**

Tobacco Use: ☐ **Yes** ☐ **No**

If so what type: ☐ **Cigarettes** ☐ **Pipe** ☐ **Cigars** ☐ **Electronic cigarettes** ☐ **Snuff** ☐ **Chew**

Year Started: _____ **Packs/day: _____** **Quit Date: _____**

Occupation: _____

Marital status: ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed**

Number of children:

Years of education: _____

Who do you live with? _____

OB/Gyn History:

Last Menstrual period: _____

Duration of periods: Interval between periods: Heavy periods: ☐ **Yes** ☐ **No**

# of pregnancies: _____ # of miscarriages: _____ # of abortions: _____

Immunizations: Please enter the dates of your most recent vaccinations

Tetanus/TDaP/Td: _____ Human Papilloma Vaccination (HPV)/Gardasil: _____

Previnar: _____ Pneumovax: _____

Zostavax /Shingles Vaccination: _____ Influenza Vaccination: _____

Preventative Care: Please enter the dates of your most recent tests

Type of Test/Procedure	Date	Result
Colonoscopy		
Sigmoidoscopy		
Hemoccult/Test for Blood in Stool		
For Women Only		
Osteoporosis Test/DEXA		
Pap Smear		
Mammogram		
Breast Exam		
For Men Only		
Last Prostate exam		
PSA		

Advanced Directives:

Do you have a living will: ☐ Yes ☐ No

Do you have a Medical Power of Attorney: ☐Yes ☐ No

Do you have an out of hospital "Do Not Resuscitate" (DNR): ☐ Yes ☐ No

If you answered YES to any of these questions, please bring a copy of the legal document to your first visit.

If you answered NO, we have information that will be provided for you to discuss with your family so that Advanced Medical Directives can be incorporated into your medical chart.