A-Z Internal Medicine
4603 Colleyville Blvd. Ste 100
Colleyville, TX 76034
Ph 817.514.8600 Fax 817.514.8601

MEDICAL HISTORY

Date________________________

Patient Name____**Date of Birth**______________
(Last) (First) (MI)

MEDICAL HISTORY List all your known medical conditions

SURGERY/INJURY List previous surgeries or injuries and approximate year

Surgery/Injury	Year	Surgery/injury	Year

HOSPITALIZATIONS List reason for any previous hospital admission and approximate year

Reason	Year	Reason	Year

FAMILY HISTORY List family member health problem and approximate age of onset

Disease	Family Member	Age of Onset
Stroke		
High Blood Pressure		
Heart Disease		
Diabetes		
Cancer/ What Type?		
Depression/Mental Illness/Suicide		

CURRENT MEDICATIONS List all medications, dosage and frequency including over the counter ones

Medication	Dosage	Medication	Dosage

DRUG ALLERGIES List medication & reaction if any

Medication	Reaction	Medication	Reaction

VACCINATIONS Date

Flu____

Pneumonia____

Shingles____

Tetanus____

SOCIAL HISTORY

Marital Status______________________Occupation______________________________

Number of Children________________

Tobacco use Type (Quantity)__________________________Quit?Date_______________Never_________

Alcohol use Type (Quantity)__________________________Quit?Date_______________Never_________

Recreational Drugs Type (Quantity)__________________________Quit?Date_______________Never_________

HIV Risk____ ☐ check if unsure

HEALTH SCREENINGS

Eye Exam Date___________________________Name of Doctor who performed____________________________

Colonoscopy Date_________________________Name of Doctor who performed____________________________

Cologuard Date___________________________

Female Patients

Date of Last Mammogram______________________Where?_____________________________________

Pap/Pelvic Exam ___________________

Menstrual Period___________________

Pregnant? ☐ Yes ☐ No ☐ Unsure