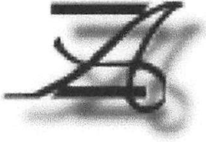

A-Z Internal Medicine
4109 Brown Trail Suite 101
Colleyville, TX 76034
Ph (817) 514-8600 Fax (817) 514-8601

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 reasons for any previous hospital admissions and approximate year(s):

Reason	Year	Reason	Year

FAMILY HISTORY

List family member and approximate age of onset:

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

CURRENT MEDICATIONS ☐ No ☐ Yes If yes, please list medications & dosage

Medication	Dosage	Medication	Dosage

DRUG ALLERGIES ☐ No ☐ Yes If yes, please list medications & reaction

Medication	Reaction	Medication	Reaction

IMMUNIZATIONS

Type	Date
____Flu________________	
____Pneumonia___________	
____Shingles____________	
____Tetanus_____________	

SOCIAL HISTORY Marital Status________________ Occupation____________________

Number of Children__________

Tobacco use Current (quantity)______________ Quit date__________Never_______

Alcohol Current (quantity)______________ Quit date__________Never_______

Recreational Drugs Type (quantity)______________ Quit date__________Never_______

HIV Risk____☐ Check if not sure

HEALTH SCREENINGS

Date of Last Eye Exam____

Colonoscopy/Cologuard________________________________

Female Patients

Date of Last Pap/Pelvic Exam ____________________

Mammogram________________________

Menstrual Period____________________

Pregnant ? ☐ Yes ☐ No ☐ Unsure