

# MEMORIAL HERMANN Medical Group

## NEW PATIENT HISTORY

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Date \_\_\_\_\_

Current Problem: \_\_\_\_\_ Date problem began: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Other Physicians: \_\_\_\_\_  
\_\_\_\_\_

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### MEDICATIONS AND MEDICATION/ DRUG ALLERGIES:

Please list medications currently taking or provide separate list:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are You Allergic to Any Medications? \_\_\_ Yes \_\_\_ No

If yes drug name and reaction: \_\_\_\_\_  
\_\_\_\_\_

Latex Allergy? \_\_\_ Yes \_\_\_ No

Previous Surgeries: \_\_\_ Yes \_\_\_ No Date: \_\_\_\_\_ Surgery: \_\_\_\_\_  
Date: \_\_\_\_\_ Surgery: \_\_\_\_\_  
Date: \_\_\_\_\_ Surgery: \_\_\_\_\_

**Habits**  
Tobacco Use: \_\_\_ No \_\_\_ Yes Type and Amount per Day \_\_\_\_\_ Age started smoking: \_\_\_\_\_  
Alcohol Use: \_\_\_ No \_\_\_ Yes Type and Frequency \_\_\_\_\_  
Drug Use: \_\_\_ No \_\_\_ Yes Type and Frequency \_\_\_\_\_  
Caffeine Use: \_\_\_ No \_\_\_ Yes Type and Frequency \_\_\_\_\_

### Family History

(M) Mother	(F) Father	(G) Grandparent	(B) Brother	(S) Sister
Arthritis, Gout	_____		Diabetes	_____
Asthma, Hay Fever	_____		Heart Disease, Stroke	_____
Breast Cancer	_____		High Blood Pressure	_____
Colon Cancer	_____		Kidney Disease	_____
Rectal Cancer	_____		Tuberculosis	_____
Chemical Dependency	_____		Other	_____

Have you ever had a blood transfusion? \_\_\_ No \_\_\_ Yes If Yes approx date(s): \_\_\_\_\_

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### Women Only:

Date of last menstrual period: \_\_\_\_\_ Date of Last Pap Smear: \_\_\_\_\_  
Date of Last Mammogram: \_\_\_\_\_ Are you Pregnant: \_\_\_\_\_  
Number of Children: \_\_\_\_\_

**Past Medical History:**

Please mark if YOU have a "PAST" history of the following:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> AIDS             | <input type="checkbox"/> Alcoholism          | <input type="checkbox"/> Anemia             |
| <input type="checkbox"/> Anorexia         | <input type="checkbox"/> Appendicitis        | <input type="checkbox"/> Arthritis          |
| <input type="checkbox"/> Asthma           | <input type="checkbox"/> Bleeding Disorders  | <input type="checkbox"/> Breast Lump        |
| <input type="checkbox"/> Bronchitis       | <input type="checkbox"/> Bulimia             | <input type="checkbox"/> Cancer             |
| <input type="checkbox"/> Cataracts        | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Chicken Pox        |
| <input type="checkbox"/> Diabetes         | <input type="checkbox"/> Emphysema           | <input type="checkbox"/> Epilepsy           |
| <input type="checkbox"/> Glaucoma         | <input type="checkbox"/> Goiter              | <input type="checkbox"/> Gonorrhea          |
| <input type="checkbox"/> Gout             | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Hepatitis          |
| <input type="checkbox"/> Hernia           | <input type="checkbox"/> Herpes              | <input type="checkbox"/> High Cholesterol   |
| <input type="checkbox"/> HIV Positive     | <input type="checkbox"/> Kidney Disease      | <input type="checkbox"/> Liver Disease      |
| <input type="checkbox"/> Measles          | <input type="checkbox"/> Migraine Headaches  | <input type="checkbox"/> Miscarriage        |
| <input type="checkbox"/> Mononucleosis    | <input type="checkbox"/> Multiple Sclerosis  | <input type="checkbox"/> Mumps              |
| <input type="checkbox"/> Pacemaker        | <input type="checkbox"/> Pneumonia           | <input type="checkbox"/> Polio              |
| <input type="checkbox"/> Prostate Problem | <input type="checkbox"/> Psychiatric Care    | <input type="checkbox"/> Rheumatic Fever    |
| <input type="checkbox"/> Scarlet Fever    | <input type="checkbox"/> Stroke              | <input type="checkbox"/> Suicide Attempt    |
| <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Tonsillitis         | <input type="checkbox"/> Tuberculosis       |
| <input type="checkbox"/> Typhoid Fever    | <input type="checkbox"/> Ulcers              | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Venereal Disease |  |   |

Please review the items below and mark with a "√" the symptoms you currently have or have had in the past year:

GENERAL		GENITO-URINARY		ENDOCRINE		CARDIOVASCULAR	
Chills		Blood in urine		Heat/Cold Intolerance		Chest Pain	
Depression		Frequent Urination		Excessive Hunger		High Blood Pressure	
Dizziness		Lack of Bladder Control		Excessive Thirst		Irregular Heart Beat	
Fainting		Painful Urination		Excessive Urination		Low Blood Pressure	
Fever		<b>MUSCULOSKELETAL</b>		Hormonal Abnormalities		Poor Circulation	
Forgetfulness		Arms/ Hands		<b>MEN ONLY</b>		Rapid Heart Beat	
Loss of Sleep		Legs/ Feet		Breast Lump		Swelling of Ankles	
Nervousness		Neck/ Shoulder		Erection Difficulties		Varicose Veins	
Numbness		Back/ Hip		Lump in Testicles		<b>EYE, EAR, AND THROAT</b>	
Sweats		<b>GASTROINTESTINAL</b>		Penis Discharge		Bleeding Gums	
		Poor Appetite		Sore on Penis		Blurred Vision	
<b>SKIN</b>		Bloating		Other		Crossed Eyes	
Bruise Easily		Bowel Changes		<b>WOMEN ONLY</b>		Difficulty Swallowing	
Hives		Constipation		Abnormal Pap Smear		Double Vision	
Itching		Diarrhea		Bleeding Between Periods		Earache	
Change in Moles		Excessive Hunger		Breast Lump		Hay Fever	
Rash		Gas		Extreme Menstrual Periods		Hoarseness	
Scars		Hemorrhoids		Hot Flashes		Loss of Hearing	
Sore that Won't Heal		Indigestion		Nipple Discharge		Nosebleeds	
		Nausea		Painful Intercourse		Persistent Cough	
		Rectal Bleeding		Vaginal Discharge		Sinus Problems	
		Vomiting		Other		Vision - Flashes	
		Vomiting Blood				Vision - Halos	

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

