Radiant
Surgical Specialists of North Texas

PATIENT MEDICAL HISTORY FORM

Name: _____ Date of Birth: _____

Reason for visit: _____

MEDICAL HISTORY

- ☐ Allergies/Hay Fever
- ☐ Alzheimer's disease
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune Disease
- ☐ Bleeding Disorder
- ☐ Blood clots
  - ☐ DVT ☐ PE
- ☐ Bronchitis or Pneumonia
- ☐ Cancer (type):_____
- ☐ Chronic pain
- ☐ Chronic steroid use
- ☐ COPD or Emphysema
- ☐ Coronary Artery Disease
- ☐ Current pregnancy
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes ☐ Use insulin?
- ☐ Diverticulosis/Diverticulitis
- ☐ Enlarged prostate
- ☐ Fibromyalgia
- ☐ GERD/Acid Reflux
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart attack
- ☐ Heart disease
- ☐ Heart murmur
- ☐ Hepatitis ☐ A ☐ B ☐ C
- ☐ High cholesterol
- ☐ HIV
- ☐ High blood pressure
- ☐ Inflammatory Bowel Disease
- ☐ Irritable Bowel Disease
- ☐ Kidney disease
  - ☐ Dialysis?
- ☐ Kidney stones
- ☐ Liver disease
- ☐ Mental illness
- ☐ Migraines
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Parkinson's disease
- ☐ Problems w/Anesthesia
- ☐ Seizures
- ☐ Stomach ulcer
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Vascular disease
- ☐ Other (please specify):

_____

MEDICATIONS			
Medication Name	**Dose**	**Medication Name**	**Dose**

SURGICAL HISTORY			
Procedure	**Date**	**Procedure**	**Date**

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ALLERGIES	
Name	**Reaction**

SOCIAL HISTORY		
Tobacco Use or history of use? Yes / No How many packs per day? _____ At what age did you start smoking? _____ When did you quit? _____	**Alcohol use? Yes / No** How much/how often? _____	**Recreational Drug Use or history of use? Yes / No** If so, list: _____

FAMILY HISTORY

	Relation		Relation
Bleeding Disorders	_____	High Blood Pressure	_____
Diabetes	_____	Anesthesia Problems	_____
Heart Disease	_____	Other (please specify)	
High Cholesterol	_____	_____	
Cancer (what type?)	_____		

REVIEW OF SYSTEMS (Check all that apply)

- ☐ Allergies/Hay Fever
- ☐ Unintentional Weight loss
- ☐ Fatigue/malaise
- ☐ Night Sweats
- ☐ Loss of appetite
- ☐ Vision Change
- ☐ Dry eyes
- ☐ Hearing loss/hearing aids
- ☐ Hoarseness
- ☐ Increased thirst/hunger/urination
- ☐ Cough
- ☐ Shortness of Breath w/rest
- ☐ Shortness of Breast w/exertion
- ☐ Sleep Apnea
- ☐ Wheezing
- ☐ Chest pain
- ☐ Palpitations
- ☐ Swelling (edema)
- ☐ Abdominal pain
- ☐ Black or Tarry stool
- ☐ Blood in stool
- ☐ Hemorrhoids
- ☐ Trouble swallowing
- ☐ Nausea
- ☐ Vomiting
- ☐ Vomiting blood
- ☐ Increased urinary frequency
- ☐ Incomplete emptying
- ☐ Difficulty Urinating
- ☐ Urinary loss of control
- ☐ Blood in urine
- ☐ Easy bruising/bleeding
- ☐ Swollen Lymph nodes/glands
- ☐ Dry skin
- ☐ Skin redness
- ☐ Skin changes
- ☐ Skin lesions/growth
- ☐ Jaundice (Yellow skin/eyes)
- ☐ Rash
- ☐ Itching
- ☐ Back Pain
- ☐ Joint Pain
- ☐ Muscle weakness
- ☐ Dizziness
- ☐ Fainting
- ☐ Headaches
- ☐ Numbness
- ☐ Memory Loss
- ☐ Anxiety
- ☐ Depression
- ☐ None of the above

_____	_____	_____
Patient Name (Print)	Patient or Representative Signature	Date