Chief Complaint/Reason for Visit: _____

Transportation Home: Name of Driver: _____ Telephone #:_____

Do you have any cultural/religious practices that will impact your health care decision? ☐ No ☐ Yes Explain: _____

Do you have a living will? ☐ No ☐ Yes Advance directives? ☐ No ☐ Yes

(To be completed by patient, family member, or responsible party. Please review and mark any problems you may have now, or have had in the past.)

☐ High Blood Pressure	☐ Fainting	☐ Jaundice	☐ Arthritis	☐ Shortness of Breath
☐ Heart Surgery	☐ Seizure Disorder	☐ Back Injury	☐ Cataracts	☐ Motion Sickness
☐ Heart Attack	☐ Blood Transfusion	☐ Neck Injury	☐ Anemia	☐ TMJ
☐ Chest Pain	☐ Leg Cramps or Pain	☐ Herniated Disc	☐ Vision Disorder	☐ Neck Pain / Stiffness
☐ Irregular Heartbeats	☐ Blood Clots	☐ Steroid Use	☐ Glaucoma	☐ False Teeth / Caps
☐ Mitral Valve Prolapse	☐ Varicose Veins	☐ Ulcer	☐ TB	☐ Loose/ Chipped Tooth
☐ Stroke	☐ Chemical Dependency	☐ Frequent Heartburn	☐ Sinusitis	☐ Kidney Disease / Stone
☐ Easy Bruising	☐ Diabetes	☐ Hiatal Hernia	☐ Recent Cold/	☐ Bladder Problems
☐ Hemophilia	☐ HIV	☐ Cancer	☐ Emphysema	☐ Prostate Problems
☐ Bleeding Tendency	☐ Liver Disease	☐ Chemotherapy	☐ Bronchitis	☐ Hoarseness
☐ Thyroid Disease	☐ Hepatitis	☐ Radiotherapy	☐ Asthma	☐ Sex. Trans. Disease
☐ Mental Illness	☐ Autoimmune Disease	☐ Prosthesis	☐ Chronic Cough	☐ Multiple Sclerosis
☐ Migraine Headache	☐ Frequent Wound Infection		☐ Fibromyalgia	☐ Sleep Apnea

Tobacco: ☐ No ☐ Yes Amount _____Packs /day for____ years.

Alcohol: ☐ No ☐ Yes Amount _____

Street/Recreational Drug? Use ☐ No ☐ Yes Types: _____

Could you be pregnant? ☐ No ☐ Yes ☐ N/A

Start date of last menstrual period: _____/_____/_____ ☐ N/A

Height _____ Weight _____

Current Medications

(include over-the-counter medications, vitamins, herbs)

NAME	DOSE	SCHEDULE	LAST TAKEN
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			

List any medical problems not listed above:

_____

_____

_____

List all previous surgeries & hospitalizations:

_____

_____

_____

_____

Implants (Surgical/Cosmetic)? ☐ No ☐ Yes If yes, what type?

_____

Problems with Anesthesia? ☐ No ☐ Yes Explain: _____

_____

Allergies (include medications, foods, environment, tape, latex, dyes below.) ☐ NO KNOWN ALLERGIES

NAME	REACTION
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	

Medical City Plano

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Plano, Texas 75075
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PATIENT IDENTIFICATION

Outpatient Services Patient Questionnaire