AUSTIN MEDICAL ASSOCIATES

2911 Medical Arts St., Bldg. 10
Austin, TX 78705

New Patient Evaluation

Name ____ Date of Exam________________

Referred by ____ Date of Birth_________________

Reason for your visit:	***Physician Notes:***
Please list your chief complaints or concerns: 1. ______________________________ 2. ______________________________ 3. ______________________________ 4. ______________________________ 5. ______________________________ 6. ______________________________ 7. ______________________________ 8. ______________________________ 9. ______________________________ 10. _____________________________	

Past Medical History:

1. Medications (All medications you are currently taking, including over the counter.)

Name | Dosage (Milligrams) | Times per day

a. ____

b. ____

c. ____

d. ____

e. ____

2. <u>Operations</u> <u>Date of operation</u>

a. ______________________________
b. ______________________________
c. ______________________________
d. ______________________________
e. ______________________________
f. ______________________________

3. Please list all previous illnesses (i.e., pneumonia, hepatitis, heart disease, hospitalizations, etc.)

<u>Illness</u> <u>Date Diagnosed</u>

a. ______________________________
b. ______________________________
c. ______________________________
d. ______________________________
e. ______________________________
f . ______________________________
g. ______________________________

4. Medication allergies (Please list) ______________________________
____

Family History

	<u>Circle</u>	<u>Age</u> (or age at death) Illnesses (or cause of death)
Mother	Living / Deceased	______________________________
Father	Living / Deceased	______________________________
Sisters	Living / Deceased	______________________________
	Living / Deceased	______________________________
Brothers	Living / Deceased	______________________________
	Living / Deceased	______________________________

Social History

1. Please circle: Married Single Children: Yes / No
2. Occupation: ______________________________
3. Hobbies (how do you spend your free time?)

4. Smoke? Yes or No If yes, how many per day

5. Alcohol Consumption? Yes or No If yes, how many per day? _____ per week? _____

Updated 06.06.16