Clark W. Brazil, M.D.
1508 Tenth, Wichita Falls, TX 76301 (940) 322-6671

HISTORY

Welcome to our practice. As a new patient, please fill out to the best of your ability all of the information below so that we may better care for you.

Date ______________________

Patient Name ______________________ **Birth Date** ______________________ **Age** ________

Referring Physician ______________________ Family Physician ______________________

SECTION 1—HISTORY OF PRESENT ILLNESS

Describe Present Problem ______________________

Where is the pain/problem? ______________________

How severe is the pain/problem on a scale of 1 – 10 with 10 being the most severe? ______________________

How long have you had the pain/problem OR ______________________

When did it start? ______________________

Does the pain/problem occur at a specific time? ______________________

Where were you at the onset of the pain/problem? ______________________

What other associated problems have you been having? ______________________

What makes the pain/problem worse or better? ______________________

Have you had this same pain/problem before? ☐ Yes ☐ No If Yes, When? ______________________

SECTION 2—PAST HISTORY: SURGERIES AND HOSPITALIZATIONS (USE BACK OF PAGE IF MORE ROOM IS NEEDED)

HAVE YOU EVER HAD SURGERY? ☐ Yes ☐ No
If Yes, please complete the following and **include all Outpatient Services / Procedures**.

Year	Reason	Year	Reason

HAVE YOU EVER BEEN HOSPITALIZED FOR PROBLEMS THAT DID NOT REQUIRE SURGERY, SUCH AS MEDICAL ILLNESSES ? ☐ Yes ☐ No
If Yes, please complete the following

Year	Reason	Year	Reason

SECTION 3—MEDICATIONS (USE BACK OF PAGE IF MORE ROOM IS NEEDED)

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING. Include all prescriptions, non-prescriptions, vitamins and herbal preparations

Name	Dosage	Frequency	Name	Dosage	Frequency

SECTION 4—ALLERGIES

MEDICATION ALLERGIES: ____________________

Other Allergies: ____________________

SECTION 5—TOXIC HABITS

HAVE YOU EVER USED TOBACCO? ☐ YES ☐ NO IF YES ☐ STILL SMOKE ☐ HAVE QUIT YEARS SINCE QUITTING ________

WHAT TYPE OF TOBACCO DID YOU USE? ☐ CIGARETTES ☐ PIPE ☐ CIGAR ☐ SNUFF/CHEWING

AMOUNT PER DAY? ____________________ HOW MANY YEARS? ____________

DO YOU USE ALCOHOL? ☐ YES ☐ NO IF YES, WHAT IS YOUR AVERAGE ALCOHOL CONSUMPTION?

(*one drink = 12 oz. beer or one glass of wine or 1.5 oz. Liquor*) ________ # of Drinks ____________________ per day/week/month/occasionally/rarely

HAVE YOU EVER HAD A SUBSTANCE ABUSE PROBLEM? ☐ YES ☐ NO IF YES, WHAT WAS YOUR DRUG OF CHOICE? ____________

IF YOU DRINK ANY OF THE FOLLOWING, PLEASE CHECK AND INDICATE HOW MUCH PER DAY.

☐ COFFEE _______ CUPS ☐ TEA _________ GLASSES ☐ OTHER CAFFEINATED BEVERAGES (SODA POP, ETC.). PLEASE LIST:

____

SECTION 6—REVIEW OF SYSTEMS

Have you ever had the following? Check only those that you have had.

General/Constitutional

- ☐ Recent Fever over 100°
- ☐ Recent Shivering/Chills
- ☐ Generalized Weakness
- ☐ Unexplained Weight Loss
- ☐ Excessive Fatigue
- ☐ Swollen Glands
- ☐ Loss of Appetite
- ☐ Other ____________

Eyes

- ☐ Discharge ☐ Right ☐ Left
- ☐ Blurring ☐ Right ☐ Left
- ☐ Pain ☐ Right ☐ Left
- ☐ Blindness ☐ Right ☐ Left
- ☐ Double vision
- ☐ Glaucoma
- ☐ Decreased Vision
  - ☐ Right ☐ Left
- ☐ Cataracts ☐ Right ☐ Left
- ☐ Other ____________

Ears/Nose/Throat

- ☐ Hearing Loss
  - ☐ Right Ear ☐ Left Ear
- ☐ Hearing Aids
  - ☐ Right Ear ☐ Left Ear
- ☐ Ringing/Buzzing/Swishing
  - ☐ Right Ear ☐ Left Ear
- ☐ Dizziness
- ☐ Dentures
  - ☐ Upper
  - ☐ Lower
  - ☐ Partial Plate
- ☐ Difficulty Swallowing
- ☐ Sore Throat
- ☐ Dry Mouth
- ☐ Nosebleeds
- ☐ Nasal Discharge
- ☐ Hoarseness
- ☐ Other ____________

Cardiovascular

- ☐ Rheumatic Fever
- ☐ Heart Disease
- ☐ Heart Attack
- ☐ Chest Pain or Pressure
- ☐ Palpitations/Skipped Beats/ Irregular Heartbeat
- ☐ Irregular Heart Rhythm
- ☐ High Blood Pressure
- ☐ Awaken at night smothering
- ☐ Angina
  - ☐ With Exertion
  - ☐ With Emotional Upset
- ☐ Have you had angina in the last
  - ☐ 1 month ☐ 3 months
- ☐ Leaky or Tight Heart Valves
- ☐ Other ____________

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Patient Name: ______________________________

Respiratory

- ☐ Hay Fever
- ☐ Asthma
- ☐ Emphysema
- ☐ New or Changed Cough
- ☐ Coughing up Blood
- ☐ Wheezing
- ☐ Shortness of Breath
- ☐ Other ______________

Gastrointestinal (Digestive System)

- ☐ Nausea/Vomiting
- ☐ Frequent Diarrhea
- ☐ Frequent Constipation
- ☐ Blood in Stools
- ☐ Black Tarry Stools
- ☐ Abdominal Pain
- ☐ Stomach Ulcers
- ☐ Colitis
- ☐ Esophageal Reflux
- ☐ Difficulty Swallowing
- ☐ Hepatitis ☐ A ☐ B ☐ C
- ☐ Last Colonoscopy ______________
- ☐ Other ______________

Genitourinary

- ☐ Urinary Frequency
- ☐ Urgency
- ☐ Difficult or Painful Urination
- ☐ Blood in Urine
- ☐ Kidney Stones
- ☐ Kidney Disease
- ☐ Other ______________

Men Only

- ☐ Lump in Testicle
- ☐ Prostate Problems
- ☐ Last PSA ___________________
- ☐ Difficulty starting/stopping stream
- ☐ Nighttime urination
  If so, how often ______________
- ☐ Impotence
- ☐ Other ______________

Women Only

- ☐ Difficulty holding urine with coughing or sneezing
- ☐ Breast Lump/Discharge
- ☐ Last Mammogram __________
- ☐ Night Sweats
- ☐ Number of pregnancies ________
- ☐ Number of births ________
- ☐ Number of miscarriages ________
- ☐ Currently or Possibly Pregnant
- ☐ Last Menstrual Period ____________
- ☐ Ovaries Removed
- ☐ Hysterectomy
  ☐ Partial ☐ Complete
- ☐ Other ______________

Musculoskeletal

- ☐ Gout
- ☐ Arthritis
- ☐ Rheumatoid Arthritis
- ☐ Osteoporosis
- ☐ Swelling of Joints
- ☐ Joint Pain
- ☐ Back Pain
- ☐ Neck Pain
- ☐ Muscle Pain
- ☐ Difficulty Walking
- ☐ Pain in Calves or Buttocks with Walking Relieved by Rest
- ☐ History of Trauma
- ☐ Weakness of Extremities
  ☐ Arms ☐ Legs
- ☐ Decreased Range of Motion
- ☐ Other ______________

Psychiatric

- ☐ Depression
- ☐ Anxiety
- ☐ Sleep Disorder
- ☐ Nervous Breakdown
- ☐ Thoughts of Suicide
- ☐ Feeling of Hopelessness
- ☐ Other ______________

Skin

- ☐ Rash
- ☐ Itching
- ☐ Moles that Change in Size or Color
- ☐ Unusual or Easy Bruising
- ☐ Hives
- ☐ Skin Cancer
  Where? _______________
- ☐ Scaling Lesions that do not Heal
  ☐ Face ☐ Ears ☐ Hands
  ☐ Leg ☐ Ankle
- ☐ Other ______________

Neurologic

- ☐ Seizures
- ☐ Migraine Headaches
- ☐ Dizzy Spells
- ☐ Stroke
- ☐ Neurologic Deficits
- ☐ Tremors
- ☐ Concussion
- ☐ Temporary Blindness
- ☐ Concussion
- ☐ Loss of Consciousness
- ☐ Difficulty with Balance
- ☐ Numbness and/or Tingling
- ☐ Problems with Coordination
- ☐ Difficulty with Memory
- ☐ Other ______________

Hematologic

- ☐ Anemia
- ☐ Blood Transfusion? When _______
- ☐ Hemophilia
- ☐ Unusual Bleeding after Injury, Small Cuts or Surgery
- ☐ Slow to Heal after Cut or Injury
- ☐ Difficulty with Bleeding after Tooth Extraction or Surgery
- ☐ Abnormal Bruising
- ☐ Phlebitis or Blood Clots in Veins
- ☐ Other ______________

Oncology

- ☐ **Cancer If so, where?**
  - ☐ Lung
  - ☐ Skin
  - ☐ Colon
  - ☐ Breast
  - ☐ Uterine
  - ☐ Prostate
- ☐ Other ______________

Lymphatic

- ☐ Enlarged Lymph Nodes
- ☐ Lymphedema
- ☐ Lymphoma
- ☐ Filariasis
- ☐ Swelling of
  ☐ Legs ☐ Hands ☐ Fingers
- ☐ Other ______________

Endocrine System

- ☐ Diabetes Mellitus
  - ☐ Diet Controlled
  - ☐ Oral Medication
  - ☐ Insulin
  - How Many Years ______
  - OR Year Diagnosed ______
- ☐ Hypoglycemia
- ☐ Thyroid Disease
- ☐ High Cholesterol
- ☐ High Triglycerides
- ☐ Tired or Sluggish
- ☐ Excessive Thirst
- ☐ Sensitive to ☐ Heat ☐ Cold
- ☐ Other ______________

Immunology/Allergic

- ☐ Immunodeficiency
- ☐ Transplant
- ☐ Autoimmune Disease
- ☐ Change in Allergies
- ☐ Other ______________

Other Medical History

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Patient Name: ____

SECTION 7—FAMILY HISTORY

			DECEASED									CANCER																						
	Relationship	Alive and Well & Age	Cause of Death	Age	Allergies	Asthma	Arthritis	Aortic Aneurysm	Alcohol/Drug Problems	Anemia	Bleeds Easily	Breast	Colon	Melanoma	Leukemia	Lung	Prostate	Other (Please List)	Diabetes	Chronic Lung Disease	Epilepsy	Glaucoma	Gout	Heart Disease	High Blood Pressure	High Cholesterol	Kidney Disease	Migraine Headaches	Psychological Problems	Skin Disease	Stroke	Thyroid Problems	Blood Clots	Artery Surgery
	Father																																	
	Mother																																	
Siblings	Brother/Sister																																	
Siblings	Brother/Sister																																	
Siblings	Brother/Sister																																	
Siblings	Brother/Sister																																	
Maternal	Grandmother																																	
Maternal	Grandfather																																	
Paternal	Grandmother																																	
Paternal	Grandfather																																	
Maternal	Aunts																																	
Maternal	Uncles																																	
Paternal	Aunts																																	
Paternal	Uncles																																	
Children	Son/Daughter																																	
Children	Son/Daughter																																	
Children	Son/Daughter																																	
Children	Son/Daughter																																	

Patient Name: ____

SECTION 8—SOCIAL HISTORY

Education: ☐ Grade School ☐ Jr. High ☐ High School ☐ College: Highest Degree ______________________
☐ Technical Training ______________________

Religious Preference: ☐ None ☐ Protestant ☐ Catholic ☐ Jewish ☐ Baptist ☐ Church of Christ
☐ Methodist ☐ Presbyterian ☐ Other ______________________

Are You Employed? ☐ Yes ☐ No Current Employer______________________

Are You Retired? ☐ Yes ☐ No Previous Occupation______________________

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Do You Live at Home? ☐ Yes ☐ No If NO, where are you currently living? ______________________

If YES, Do You Live Alone? ☐ Yes ☐ No If NO, Who Lives with You? ______________________

Are You Able to Care for Yourself? ☐ Yes ☐ No Do You Have Assistance? ☐ Yes ☐ No If YES, from whom:
☐ Family ☐ Housekeeper ☐ Nursing Service Name of Nursing Service ______________________

How Many Children do You Have? __________ Where do They Live? ______________________

____

Where Have You Lived (States/Countries) ______________________

Have you ever visited/vacationed any tropical country, specifically Africa, Eastern Mediterranean, Southeast Asia? ☐ Yes ☐ No

How Long Have You Lived at Your Present Address? ______________________

Have You Ever Been in the Military? ☐ Yes ☐ No If YES, Which Branch?______________________

How Long were You in the Military? ______________ Where Have You Been Stationed? ______________________

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What are Your Daily Activities?______________________

What are Your Hobbies and Interests? ______________________

Do you have any physical disabilities that keep you from certain activities? ☐ Yes ☐ No If YES, what is your main physical disability? ______________________

ENVIRONMENTAL EXPOSURES:

HAVE YOU EVER HAD ANY EXCESSIVE EXPOSURE AT HOME OR WORK TO ANY OF THE FOLLOWING?

POLLUTANT	NAME	WHEN
☐ Fumes		
☐ Dust Particles		
☐ Solvents		
☐ Air-borne particles		
☐ Noise		
☐ Insecticides		
☐ Other Exposure		

IS THERE ANYTHING ELSE THAT YOU FEEL THE DOCTOR NEEDS TO KNOW IN ORDER TO GIVE YOU THE BEST MEDICAL CARE POSSIBLE?

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Patient Name: ______________________