



598 N. Union Ave., Suite 230
 New Braunfels, TX 78130
 (830) 627-3777

Past Medical History Information

Today's Date: _____ Patient's Name: _____ Date of Birth: _____

Social Security Number: _____ Primary Care Physician: _____

Reason for today's visit: _____

Please list your past surgeries/hospitalizations with dates: _____

Please check **Yes** if you have or **No** if you do not have each of the medical conditions listed below:

Medical Conditions	Yes	No	
Angina (chest pain)			
Hypertension (high blood pressure)			
Diabetes (high blood sugar)			
Renal Disease (kidney disease)			
Respiratory Illness (lung problems)			Please list type (ie. Asthma, COPD, etc.):
Bleeding Disorder			
Seasonal Allergies			
HIV/AIDS			
Cancer			Please list type of cancer:
Sinus Problems			
Recent Viral Illness (flu-like illness)			

Please describe any current or past medical condition not listed above: _____

Is there a family history of the illness/condition we are seeing you for today? If so, please specify relationship of family member.

Please list your drug allergies: _____

Do you currently smoke or chew tobacco? Yes No How many packs per day? _____

Do you drink alcohol, beer, or wine? Yes No How many drinks per week? _____

I herby certify that to the best of my knowledge all the information I have furnished on this form is complete, true, and accurate.

 Patient's Signature

 Today's Date

