

FULL NAME:	
DATE OF BIRTH: _	
DATE:	

New Patient Acute/Sick Visit

Thank you for choosing North Dallas Primary Care Doctors. We appreciate your assistance by completing this form, as it will help us better care for you.

Reason for visit:

Allergies:

List any significant reactions to food/meds

No known allergies

Allergy	Reaction

Medications:

List any medications you take, prescription and nonprescription and their dosage:

Medication	Dose	Medical reason for taking

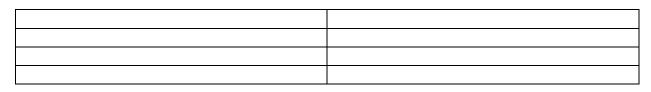
Local Pharmacy:	Phone Number:

Address: _____ City: _____

Immunizations: Please enter the dates of your most recent vaccinations

Influenza Vaccination: _____ COVID 19 vaccine _____

Your Care Team: Please provide the names of any other providers that you currently receive care from.



Past Medical History: Please check all that apply.

□ No medical problems

Abnormal pap smear	Deep Vein Thrombosis
Anemia	Depression
Anxiety	Diabetes type 1 or 2
Asthma	GERD
Atrial fibrillation	Gestational Diabetes
Breast cancer	GI bleed
Cervical cancer	Gout
Chicken pox	Hepatitis A
Chronic Back pain	Hepatitis B
Colon Cancer	Hepatitis C
COVID 19	Hypertension

Hyperthyroidism
Hypothyroidism
Kidney Stone
Heart attack
Kidney Disease
Kidney Failure
Seizures
Skin Cancer
Stroke
Substance Abuse
Ulcers

Additional History:

□ N/A

Past Surgical history:

Abdominal aneurysm Appendectomy Back Surgery Bariatric Surgery Brain Surgery Breast Biopsy R/L Breast Enhancement Breast Surgery R/L CABG-Heart bypass Cardiac catheterization

Carotid

Endarterectomy Carpal Tunnel R/L

Cataract Surgery R/L
Cerebral Aneurysm
Colon Surgery
Gall Bladder removal
Heart Transplant
Hip Surgery R/L
Hysterectomy
Hysterectomy with
ovaries removed
Kidney removal R/L
Kidney Transplant
Knee arthroscopy
Knee Surgery R/L

□ No surgical history

Liver Transplant
Lung Transplant
Mastectomy (breast
removal) R/L
Neck Surgery
Previous C-section
Shoulder Surgery R/L
Sinus Surgery
Tonsillectomy
Tubal ligation (tubes tied)
Valve replacement
Other:

Family History: Please check all that apply:

No Family history

	none	Alcohol abuse	Alzheimer's	Asthma	Autoimmune	Breast cancer	Cancer	Colon cancer	COPD/Bronchitis	Depression	Diabetes	Heart Disease	Hyperlipidemia	Hypertension	Lung Cancer	Melanoma	Osteoporosis	Ovarian Cancer	Prostate Cancer	Seizures	Stroke	Thyroid Disease
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Mother																						
Father																						
Sister																						
Brother																						
Daughter																						
Son																						
Mat GM																						
Mat GF																						
Pat GM																						
Pat GF																						
Other:																						

Social History:

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OB/Gyn History:

Last Menstrual period:	_ Duration of periods:	Interval between periods:	
Heavy periods: 🗆 Yes 🛛 No			