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: ☐ **No medications**

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
	Anemia
	Anxiety
	Asthma
	Atrial fibrillation
	Breast cancer
	Cervical cancer
	Chicken pox
	Chronic Back pain
	Colon Cancer
	COVID 19

	Deep Vein Thrombosis
	Depression
	Diabetes type 1 or 2
	GERD
	Gestational Diabetes
	GI bleed
	Gout
	Hepatitis A
	Hepatitis B
	Hepatitis C
	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: ☐ No 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

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
Mother																						
Father																						
Sister																						
Brother																						
Daughter																						
Son																						
Mat GM																						
Mat GF																						
Pat GM																						
Pat GF																						
Other:																						

Social History:

Alcohol Use: ☐ Yes ☐ No
Number of drinks/week: _____ glasses of wine _____ cans of beer _____shots of liquor

Sexually Active: ☐ Yes ☐ not currently ☐ Never
Type of birth control: _____Partners: ☐ Female ☐ Male ☐ Both
Drug Use: ☐ Yes ☐ No ☐ Former Type of Drug(s): _____

Tobacco Use: ☐ Yes ☐ No ☐ Former
If so what type: ☐ Cigarettes ☐ Pipe ☐ Cigars ☐ Electronic cigarettes ☐ Snuff ☐ Chew
Year Started: _____ Packs/day: _____ Quit Date: _____

Occupation: _____
Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Number of children: _____

OB/Gyn History:

Last Menstrual period: _____ Duration of periods: _____ Interval between periods: _____
Heavy periods: ☐ Yes ☐ No