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.

Date: _______________

Name:____ **Date of Birth:** ______________________

Reason for visit:____

Allergies:

List any significant reactions to food/medication ☐ **No known allergies**

Allergy	Reaction

Medications:

List any medications you take, prescription and nonprescription and their dosage: ☐ **No medications**

Medication	Dose	Refill needed Y/N

Local Pharmacy: _____________________________**Phone Number:** __________________________
Address: ____ **City:** __________________________
Mail order Pharmacy: ____

Past Medical History: Please circle all that apply. ☐ **No medical problems**

Abnormal Pap Smear	Chronic Back pain	Diabetes TYPE 2	Hyperlipidemia	Kidney Transplant
Anemia	Colon Cancer	GI Bleed	Hypertension	Rheumatoid Arthritis
Anxiety	COVID 19 infection	Gout	Hypothyroidism	Seizures
Asthma	COVID 19 exposure	Hepatitis A	Hyperthyroidism	Skin Cancer
Atrial Fibrillation	Deep Vein Thrombosis	Hepatitis B	Heart Attack	Stroke
Breast Cancer	Depression	Hepatitis C	Kidney Disease	Stomach Ulcers
Cervical Cancer	Diabetes TYPE 1	HIV	Kidney Failure	

Additional Medical History: ____

Past Surgical history:

☐ **No surgical history**

Abdominal aneurysm	Cataract Surgery R/L	Liver Transplant
Appendectomy	Cerebral Aneurysm	Lung Transplant
Back Surgery	Colon Surgery	Mastectomy (breast removal) R/L
Bariatric Surgery	Gall Bladder removal	Neck Surgery
Brain Surgery	Heart Transplant	Previous C-section
Breast Biopsy R/L	Hip Surgery R/L	Shoulder Surgery R/L
Breast Enhancement	Hysterectomy	Sinus Surgery
Breast Surgery R/L	Hysterectomy with ovaries removed	Tonsillectomy
CABG-Heart bypass	Kidney removal R/L	Tubal ligation (tubes tied)
Cardiac catheterization	Kidney Transplant	Valve replacement
Carotid Endarterectomy	Knee arthroscopy	Other:
Carpal Tunnel R/L	Knee Surgery R/L	

Family History:

☐ **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:																						

OB/Gyn History: (Women Only)

Last Menstrual period: _________

Duration of periods: ______ Interval between periods: ______ Heavy periods: ☐ Yes ☐ No

# of pregnancies: _________ # of miscarriages: _________ # of abortions: _________

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

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

Circle type of birth control used: None Condoms IUD Vasectomy Pills

Partners: ☐ Female ☐ Male ☐ Both

Number of children: _______

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: ____

Years of education: ________

Immunizations: **Please enter the dates of your most recent vaccinations**

Tetanus/TDAP/Td: ________ Human Papilloma Vaccination (HPV)/Gardasil: ________

Prevnar: ________ Pneumovax: ________ Zostavax /Shingles Vaccination: ________

Influenza Vaccination: ________ COVID 19 vaccine _____________

Preventative Care: **Please enter the dates of your most recent tests**

Type of Test/Procedure	Date	Result
Colonoscopy		
Sigmoidoscopy		
Hemoccult/Test for Blood in Stool		
Diabetic Eye Exam		
For Women Only		
Osteoporosis Test/DEXA		
Pap Smear		
Mammogram		
Breast Exam		
For Men Only		
Last Prostate exam		
PSA		

Advanced Directives:

Do you have a living will: ☐ **Yes** ☐ **No**

Do you have a Medical Power of Attorney: ☐**Yes** ☐ **No**

Do you have an out of hospital "Do Not Resuscitate" (DNR): ☐ **Yes** ☐ **No**

If you answered YES to any of these questions, please bring a copy of the legal document to your first visit.

If you answered NO, we have information that will be provided for you to discuss with your family so that Advanced Medical Directives can be incorporated into your medical chart.