TOLEDO BEND FAMILY MEDICINE
2421 Worth Street, Hemphill, Texas 75948
Phone: (409) 787-1416 Fax: (409) 787-1419

Patient Name _____ Age _____ DOB _____ Date _____

Pharmacy Name _____ Location _____ Phone _____

Any known allergies? ☐ Yes ☐ No If yes describe _____

MEDICAL HISTORY

Please check the appropriate answer if you have or have had:

Prolonged bleeding when cut	☐ Yes	☐ No	Shortness of breath/lung problems	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Fainting or blackout spells	☐ Yes	☐ No
Stomach/Intestinal disorder	☐ Yes	☐ No	Visual Problems	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No	Joint Pains	☐ Yes	☐ No
Heart trouble/disease	☐ Yes	☐ No	Excessive scarring	☐ Yes	☐ No
Heart murmur	☐ Yes	☐ No	Autoimmune disorder	☐ Yes	☐ No
Irregular pulse	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Any other significant illness	☐ Yes	☐ No

If other, please describe _____

FAMILY HISTORY Please indicate **P** for father's side of the family or **M** for mother's side. Please indicate relationship (M-Mother; F-Father; B-Brother; S-Sister; GM-Grandmother, GF-Grandfather, O-Other)

Diabetes	☐ **P**	☐ **M**	_____	High blood pressure	☐ **P**	☐ **M**	_____
Heart Disease	☐ **P**	☐ **M**	_____	Liver disease	☐ **P**	☐ **M**	_____
Stomach/Intestinal disorder	☐ **P**	☐ **M**	_____	Lung disorder	☐ **P**	☐ **M**	_____
Bleeding disorders	☐ **P**	☐ **M**	_____	Emotional problems	☐ **P**	☐ **M**	_____
Bone or joint problems	☐ **P**	☐ **M**	_____	Cancer	☐ **P**	☐ **M**	_____
Any other significant illness	☐ **P**	☐ **M**	_____	If other, please describe			_____

PERSONAL HISTORY

Do you smoke? ☐ Yes ☐ No If yes, how many cigarettes/packs per day? _____

Do you drink alcohol? ☐ Yes ☐ No If yes, how much and how often? _____

Do you take vitamins and/or supplements? ☐ Yes ☐ No

If yes, please list _____

Please list previous surgeries _____

_____

_____

Please list any medications taken regularly, including aspirin and birth control pills.

Medication Name	_____	Dosage/frequency	_____
Medication Name	_____	Dosage/frequency	_____
Medication Name	_____	Dosage/frequency	_____
Medication Name	_____	Dosage/frequency	_____
Medication Name	_____	Dosage/frequency	_____

Have you ever had a blood transfusion? ☐ Yes ☐ No Date(s): _____

Have you taken Aspirin-containing drugs in the past two weeks? ☐ Yes ☐ No

Previous Primary Care Physician Information _____

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