Toledo Bend FAMILY MEDICINE
A MEMBER OF THE PREFERRED FAMILY

2421 Worth St
Hemphill, Tx 75948
Phone:409-787-1416
Fax: 409-787-1419

PATIENT MEDICAL HISTORY

Date: _____

Patient Name: _____ DOB: _____Age: _____

Smoke: Y or N, if yes how many cigarettes or packs a day? _____

Do you Vape? Y or N Do you use Tobacco (chew) Y or N how much daily? _____

Do you Drink Alcohol: Y or N If yes, how much and how often?

Daily – Weekly - Monthly - Socially – Occasionally _____

Allergies: Y or N-Please List: _____

Pharmacy Name/City/State: _____ Phone: _____

Specialist:

_____

_____

MEDICAL HISTORY

Please CIRCLE **the appropriate answer if you have or have had any of the following:**

Diabetes	GERD	COPD
High Blood Pressure	Stomach Disorder	Asthma
High Cholesterol	Kidney Disease	Emphysema
Coronary Artery Disease	Rheumatoid Arthritis	Lung Problems: _____
Congestive Heart Failure	Arthritis	Visual Problems: _____
Heart Murmur	Lupus	Fainting/Blackout Spells
Heart Problem/Disease	Autoimmune Disorder	Liver Disease
Irregular Pulse	Depression	Anxiety
Chron's	Hepatitis A, B, C	**Cancer: _____**

List any other significant illness and Surgeries.

_____

_____

_____

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

Medication Name: _____ Dose _____ Directions _____

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