dell children's
medical center of central texas
A member of the Seton Family of Hospitals

MEDICAL HISTORY (ADULT)

Patients Name: _____
Date of Birth: _____/_____/_____
Consent to Text ___Yes ___No to receive automated text alerts to your mobile phone for appointment reminders, test results, and more.
Patient Email: _____

Medical History

List all current and/or chronic medical problems: _____
_____
_____
_____
List all past medical problems, surgeries, or hospitalizations: _____
_____
_____
_____
List all current prescription or over the counter medications: _____
_____
_____
List all allergies to medications: _____
Who is your internist or family practitioner? _____
Do you see any other specialists? _____
Pharmacy name and phone number: _____

Ocular History

List all current or past eye problems or any eye surgery: _____
_____
_____
List any eye injury that required medical attention: _____
_____

Family History

Please list all eye problems (glaucoma, lazy eye, misalignment of the eyes, or cataracts at a young age) of your family members. List all major medical problems known to run in your family.

_____
_____
_____
_____
Do you have a family member with malignant hyperthermia during anesthesia (high temperature and muscle breakdown)? [ ] No [ ] Yes

Social History

What are your hobbies and interests? _____
Occupation: _____ Marital Status: _____
Do you smoke? _____ If yes, how many packs per day? _____
Do you drink alcohol? _____ If yes, how many drinks per day? _____
Is it okay to leave test results, etc. on your voicemail at home and/or work? _____

What is the reason for your visit today? _____
_____
_____
_____

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REVIEW OF SYSTEMS (ADULT)

Patient Name: _____
Date of Birth: _____/_____/_____

Do you have any symptoms or issues in any of these areas **TODAY**?

IF NO, WRITE NO OR IF YES, PLEASE EXPLAIN

Constitutional_____
(fever, weight loss, poor appetite)
Ears, nose, throat_____
(congestion, cough)
Heart_____
(chest pain, palpitations)
Lungs_____
(wheezing)
Gastrointestinal_____
(nausea, vomiting, diarrhea)
Genitourinary_____
(trouble with urination, pain)
Musculoskeletal_____
(joint pain, swelling)
Skin_____
(rash, itching)
Neurologic_____
(seizures, weakness, CP, numbness)
Psychiatric_____
(depression, behavior problems)
Endocrine_____
(growth problems, menstrual problems, too hot, too cold)
Hematologic_____
(easy bruising or bleeding)
Allergic/ Immunologic_____
(rash, itching, hay fever)

If you are having **double vision**, **droopy eyelids**, or **vision loss** in one or both eyes, please place a checkmark by any of the symptoms that you are currently experiencing or have experienced in the last few months.

____ headaches on your temple(s)
____ tenderness when you touch your temples
____ pain when you brush/comb your hair
____ pain on the back of your head
____ pain in jaw with chewing (not TMJ)
____ unintentional weight loss
____ difficulty breathing (not wheezing/ asthma)
____ difficulty swallowing
____ arm or leg weakness
____ difficulty holding head up
____ twitching muscles
____ muscle aches and pains