HEALTH TEXAS
MEDICAL GROUP OF SAN ANTONIO

Confidential Health Questionnaire

Patient Name:_____DOB:_____Today's Date:_____

Please mark with a (✓) any of the following illnesses and medical problems you have or have had and indicate the year when each started.

ILLNESS

- ☐ Vision Loss/Blindness_____
- ☐ Glaucoma_____
- ☐ Cataracts_____
- ☐ Hearing Loss or Ear Problems_____
- ☐ COPD or Emphysema_____
- ☐ Pneumonia_____
- ☐ Seasonal Allergies_____
- ☐ Asthma_____
- ☐ Tuberculosis_____
- ☐ Other Lung Problems_____
- ☐ Vascular Disease (plaque in arteries)_____
- ☐ Heart Murmur_____
- ☐ Heart Disease_____
- ☐ High Cholesterol_____
- ☐ High Blood Pressure_____
- ☐ Other Heart Conditions_____
- ☐ Hernia_____
- ☐ Hemorrhoids_____
- ☐ Anemia_____
- ☐ Cancers _____
- ☐ Other Health Problems _____

- ☐ Stomach/Duodenal Ulcer_____
- ☐ Colitis or Diverticulosis_____
- ☐ Liver disease or Hepatitis_____
- ☐ Stroke or TIA_____
- ☐ Seizures_____
- ☐ Depression or Anxiety_____
- ☐ Headaches_____
- ☐ Dementia or Memory Loss_____
- ☐ Arthritis or Gout_____
- ☐ Thyroid Nodules_____
- ☐ Hypo or Hyperthyroid_____
- ☐ Diabetes _____
- ☐ Diabetic Nerve Pain/Numbness_____
- ☐ Diabetic Foot Infections_____
- ☐ Diabetic Eye Disease _____
- ☐ Amputation(s)_____
- ☐ Kidney Disease_____
- ☐ Recurrent Bladder Infections_____
- ☐ Bladder Incontinence_____
- ☐ Other Kidney problems_____

MALES ONLY:

- ☐ Prostate Enlarged or Cancer_____
- ☐ Impotence or Erectile Dysfunction_____

FEMALES ONLY:

- ☐ Gynecological/Obstetrical_____
- ☐ Breast Problems_____

Cancer Screenings and Routine Health Maintenance:

Females Only:

Last PAP_____ Last Mammogram_____

Last Pelvic exam_____

MEN and **WOMEN** Colon Cancer Screening with stool cards **OR** colonoscopy (date)_____

Please list name of physician who performed Colonoscopy_____

(Over)

VACCINES: (Year) Tetanus:_____ Pneumonia:_____ Zostavax (Shingles):_____Flu:_____

Last Primary Physician name/address/number:_____
Please sign a release today for these records _____
Please list all Specialists you currently see: _____
_____
_____

Please list all times you have been hospitalized, operated on, or injured.

Year	Operation, Illness or Injury	Hospital and City

Current Medications: _____ _____
_____ _____
_____ _____
_____ _____

ALLERGIES _____ _____

Non-prescription drugs or supplements:_____
_____
Smoking or Tobacco products: Packs per day_____Years_____ Quit date:_____
Alcohol drinks per day or month:_____ Drug use:_____
Sexual Orientation:_____

Your Family's Health History

	Age if Living	Age at Death	Did/Do they have High Blood Pressure, Heart Disease, Strokes, Cancers or Diabetes?	State of health or Cause of death
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Siblings	_____	_____	_____	_____
Spouse	_____	_____	_____	_____
Children	_____	_____	_____	_____

Do you have an **Advanced Directive** or **Living Will**? _____

Do you have a **Medical Power of Attorney**? _____ Who is it?_____

Patient Signature _____ Date _____

Name/Relationship of Individual Completing Form (if other than patient) _____