

William H. Bordelon, M.D., P.A.
1600 S. Coulter, Bldg A, Suite 100
Amarillo, Texas 79106
(806) 359-5874

Medical History

Patient's Name: _____ Age: _____ Today's Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: () _____ Work _____ Cell _____

Social Security Number: _____ Marital Status: _____ Date of Birth: _____

Emergency contact: _____ Relationship: _____ Phone number: _____

Please answer all the questions. If you do not understand the questions, insert a question mark (?) in the space.

Please leave no blanks. Your answers will be treated confidentially.

Referring Physician: _____

Other Physicians involved in your care: _____

Brief description of current problem: _____

Current Medications: (List all medications you are now taking, including those you buy without a doctor's prescription, such as aspirin, vitamins, etc.) Please list name and dosage.

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

7. _____ 8. _____

9. _____ 10. _____

11. _____ 12. _____

Allergies or Sensitivities to Medications:

Allergic to: _____ Effect: _____

Allergic to: _____ Effect: _____

Allergic to: _____ Effect: _____

Sensitive to: _____ Effect: _____

PAST MEDICAL HISTORY

Please list all the times you have been hospitalized, operated on, or seriously injured:

<u>Year</u>	<u>Operation, illness or serious injury</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

SOCIAL AND PERSONAL HISTORY

Marital status: _____ x _____ years. Occupation: _____ Retired? _____ x _____ years

Tobacco? Yes No Kind: _____ How much: _____ For how long: _____

Alcohol? Yes No Kind: _____ How much: _____ How often: _____

Exercise regularly? Yes No Kind: _____ How many times a week? _____

Hobbies: _____

HAVE YOU EVER:

Taken pain pills or pain shots for long periods of time: Yes No

Received blood transfusions: Yes No Explain: _____

FAMILY HISTORY:

	<u>Age if living</u>	<u>Age at death</u>	<u>State of health or cause of death</u>
Father:	_____	_____	_____
Mother:	_____	_____	_____
Brother:	_____	_____	_____
	_____	_____	_____
Sister:	_____	_____	_____
	_____	_____	_____

Check any diseases which may “run in your family”: (Give details on last page) Diabetes: _____ Heart disease: _____

Kidney disease: _____ Cancer: _____ Bleeding problems: _____ Seizures or epilepsy: _____ Gout: _____

High blood pressure: _____ Stroke: _____ Prostate Cancer: _____ Other: _____

DO YOU HAVE OR HAVE YOU BEEN TREATED FOR:

- | | | | |
|--|--|---|--|
| 1. Chills, fatigue, fever or weight change | Yes <input type="checkbox"/> No <input type="checkbox"/> | 14. Abdominal pain, heartburn, nausea or vomiting | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 2. Any disease or disorder of the ears, nose or throat | Yes <input type="checkbox"/> No <input type="checkbox"/> | 15. Any constipation, diarrhea, or change in bowel habits | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. Hearing problems | Yes <input type="checkbox"/> No <input type="checkbox"/> | 16. Any bleeding from stomach, intestines or rectum | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 4. Congestion, running nose, nosebleeds, or sore throat | Yes <input type="checkbox"/> No <input type="checkbox"/> | 17. Any disease of the liver, gallbladder pancreas or spleen | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 5. Heart murmur, rheumatic fever, or any other disease or disorder of the heart or blood vessels | Yes <input type="checkbox"/> No <input type="checkbox"/> | 18. Frequent urination, dysuria, or incontinence | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 6. Chest pain or discomfort, palpitations, or elevated blood pressure | Yes <input type="checkbox"/> No <input type="checkbox"/> | 19. Infections of the kidney, bladder or urine | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 7. Shortness of breath at night | Yes <input type="checkbox"/> No <input type="checkbox"/> | 20. Genital lesions, herpes, or any other sexually transmitted disease | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 8. Any swelling of your ankles | Yes <input type="checkbox"/> No <input type="checkbox"/> | 21. Arthritis, gout or any disease or disorder of the joints, muscles, bones or spine | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 9. Any disease or disorder of the lungs | Yes <input type="checkbox"/> No <input type="checkbox"/> | 22. Any dizziness, headaches, loss of sensation, or muscular weakness | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 10. Shortness of breath, persistent hoarseness, or chronic cough | Yes <input type="checkbox"/> No <input type="checkbox"/> | 23. Any disease of the brain or nerves | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 11. Asthma, emphysema, tuberculosis | Yes <input type="checkbox"/> No <input type="checkbox"/> | 24. Any easy bruising, bleeding, or enlarged lymph nodes | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 12. Any bloody sputum | Yes <input type="checkbox"/> No <input type="checkbox"/> | 25. Any non-medication allergies, frequent upper respiratory infections, or history of allergic reactions | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 13. Any disease or disorder of the stomach, intestines or rectum | Yes <input type="checkbox"/> No <input type="checkbox"/> | 26. HIV infection or exposure | Yes <input type="checkbox"/> No <input type="checkbox"/> |

Please identify, by number, any questions answered “YES” and give details:
