

George Nunez, Jr., MD, PA
 201 Kingwood Medical Drive, Suite B-600
 Kingwood, Texas 77339
 281-358-3702 office
 281-348-9510 Fax

MEDICAL HISTORY

Patient Name: _____ Date: _____

Drug Allergies: _____

No Known Drug Allergies

Current Medications: See Current Medication Form No Medications

Past surgeries/hospitalizations with dates: _____

Past Medical History:

- | | | |
|---|---|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Bloating/Gas |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Colon Cancer |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> High Triglycerides | <input type="checkbox"/> Colon Polyps |
| <input type="checkbox"/> Chronic Rash | <input type="checkbox"/> Prostate Disease | <input type="checkbox"/> Crohn's Disease |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Sexual/Menstrual Dysfunction | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Gallbladder problems |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Irritable Bowel Syndrome |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Pancreatitis | _____ |
| <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Stomach Ulcer | _____ |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Acid Reflux | |
| <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Anemia | |
| <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Bowel Irregularity | |

Social History:

Current Smoker: Yes No
 Ever Smoked: Yes No
 Packs Daily: _____ How long: _____
 Cups of Coffee per day: _____
 Other Caffeinated Drinks per day: _____
 Current Exercise Routine: _____
 Alcohol Intake Type/Amount: _____
 Fat Intake: _____
 Hours of sleep/night: _____
 Blood/body fluids exposure: Yes No
 Toxic Chemical Exposure: Yes No
 Tattoos: Yes No
 Explanation: _____

Family Medical History:

	Father	Mother	Siblings	Children
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

For Women Only:

Age of first menstruation: _____ Days between each cycle: _____
 Period lasts: ____ days. Flow is: Light Moderate Heavy
 Date of last period: __/__/____ Are you pregnant? Yes No
 Total # of pregnancies: _____ Full term deliveries: _____
 Living children: _____ Age of youngest: _____
 Last Pap exam: _____ Last breast exam: _____
 Type of birth control: _____