Mark B. Blick D.O., P.A. ● Rene E. Darveaux M.D., P.A. ● Danny D. Cheng M.D., P.A. ● JoAnne L. Rogers, M.D., P.A.
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Joy H. Vonk, PA-C
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6565 W. Loop South Ste# 300, Bellaire, Texas 77401
Office# (713) 850-7272 Fax# (713) 877-0970

Medical History Form

General Information:
Name: _____ Age:_____ Birthdate:_____
Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated
If married, spouse's name: _____ Children's names/ages: _____
Address: _____
Home #: _____ Cell #:_____ Work #:_____
Emergency Contact: _____ Phone #: _____

Allergies: If yes, please list name of medicine, x-ray dye, or other substance and type of reaction
Medication Allergy: ☐ No ☐ Yes
_____
_____
_____

Current Medications: Prescription, over-the-counter, vitamins, herbs, etc. (write on back as needed)

Drug Name	*Dosage*	*Drug Name*	*Dosage*
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Past Medical History: Please check off if **you** have had, or are having, any problems with the following:
Heart: ☐ High blood pressure ☐ High cholesterol ☐ Coronary artery disease ☐ Heart attack ☐ Valve disease ☐ Blood clot **Lung:** ☐ Asthma ☐ COPD ☐ Pneumonia ☐ Sleep Apnea ☐ Tuberculosis **Gastric:** ☐ Gallbladder stones ☐ Acid reflux ☐ Hepatitis ☐ IBS ☐ Ulcers **Renal/Urinary/Gynecologic:** ☐ Renal failure ☐ Renal stones ☐ Incontinence ☐ Enlarged prostate ☐ Endometriosis ☐ Fibroids ☐ PCOS **Muscle/Joint:** ☐ Gout ☐ Osteoarthritis ☐ Osteoporosis ☐ Rheumatoid Athritis **Endocrine:** ☐ Diabetes (type _____) ☐ Hyperthyroidism ☐ Hypothyroidism **Blood:** ☐ Anemia (type _____) ☐ Sickle cell ☐ Thalassemia **Immune:** ☐ Allergies ☐ Eczema ☐ Chicken pox ☐ Psoriasis ☐ Shingles **Mood:** ☐ Anxiety ☐ Depression ☐ Bipolar ☐ Schizophrenia ☐**Cancer:** (list type, age/year of diagnosis, and treatment) _____ **Miscellaneous:** ☐ Obesity ☐ Glaucoma ☐ Cataract ☐ Headache ☐ Multiple Sclerosis ☐ Parkinson's ☐ **Other** _____

Gynecologic/ Obstetric History: Age at onset of periods: _____ Frequency: _____
Length: _____ Pregnancies: _____Births: _____ Miscarriages: _____ Abortions: _____ Medication
Prolonged or abnormal bleeding: ☐ No ☐ Yes (Please describe) _____
Pelvic pain: ☐ No ☐ Yes (Please describe) _____
History of abnormal Pap smear: ☐ No ☐ Yes (Please describe) _____

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BELLAIRE DOCTORS CLINIC

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Specialists/Other Medical Providers: (example: Dr. Smith, annual eye exam)

Name	*Reason*	*Name*	*Reason*
_____	_____	_____	_____
_____	_____	_____	_____

Operations/ Hospitalizations:

Operation	*Date*	*Hospitalization Reason*	*Date*
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Family History: Has your parents, grandparents, siblings, etc., ever had the following?
Cancer (describe type and age of diagnosis):_____
Hypertension:_____
Heart Disease:_____
Diabetes:_____
Thyroid Disease:_____
High Cholesterol:_____
Stroke:_____
Mental Illness (anxiety, depression, etc.): _____
Drug or alcohol addiction:_____

Social History: Occupation: _____ Hobbies: _____ Do you have a living will? ☐ No ☐ Yes
Exercise: ☐ No ☐ Yes, type and frequency_____ Smoking: ☐ No ☐ Yes, # of packs/day
_____ since age _____ or quit date: _____ Alcohol: ☐ No ☐ Yes, frequency _____
Illicit Drugs: ☐ No ☐ Type, how often _____

Prevention: Please note year of last:
Tetanus Vaccine: _____ Influenza Vaccine: _____Pneumococcal Vaccine: _____
Routine labs: _____Colonoscopy: _____ Mammogram: _____ Pap smear: _____

I agree that the above information is complete and correct and that I will inform my provider of any future updates. I understand this information is for use by my provider as part of my confidential medical record.

X_____ _____
(Signature of Patient/Parent/Guardian) **(Date)**