



DIAGNOSTIC PARTNERS OF NORTH TEXAS, P.A

1600 Coit Rd, Ste 101, Plano TX 75075, Ph# 972-867-9507

Murphy Medical Clinic, 517 West FM 544, Ste 100, Murphy TX 75094

Ph # 972-578-7700 Fax # 972-578-7705

Name: _____ DOB: _____ Gender M F Date: _____

Past Medical History

1. Do you have Asthma? No Yes
2. Do you have abnormal heart rhythm? No Yes
3. Do you have Arthritis? No Yes
4. Do you have high blood pressure? No Yes
5. Do you have diabetes? No Yes
6. Do you have high cholesterol? No Yes
7. Do you have any blood disorder? No Yes
8. Do you have Kidney Disease? No Yes
9. Do you have any type of Cancer? No Yes
10. Do you have Thyroid problems? No Yes
11. Have you ever had heart problems? No Yes
12. Do you have Rheumatic heart disease? No Yes
13. Do you have liver disease? No Yes
14. Have you ever had gastric problems? No Yes
15. Have you ever had Measles, Mumps and Rubella? No Yes
16. Have you ever had tuberculosis? No Yes
17. Have you ever had chicken pox? No Yes
18. Have you ever had Congenital Abnormalities? No Yes
19. Do you have any serious/incurable disease? No Yes
20. Have you ever had a blood transfusion? No Yes
21. Have you ever had head injuries? No Yes
22. Have you ever been knocked unconscious? No Yes
23. Have you ever been in a motor vehicle accident? No Yes
24. Have you ever had any hospitalization? No Yes
25. Do you have any medication allergies? No Yes

If yes, please list _____



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Past Medical History Cont'd

26. Over the past two weeks, have you felt down, depressed
or hopeless? No Yes
27. Over the past two weeks, have you felt little interest
or pleasure in doing things? No Yes

MEDICAL HISTORY CONT'D

Surgical History

1. Have you ever had an appendectomy No Yes
2. Have you ever had a gastric bypass? No Yes
3. Have you ever had heart bypass surgery? No Yes
4. Have you had gallbladder surgery? No Yes
5. Have you had a joint replacement? No Yes
6. If female, have you had a hysterectomy? No Yes
- If Yes: Complete Partial
7. If male, have you had a vasectomy? No Yes

Immunizations

1. Do/Did you have/had Hep A/Hep B vaccination? No Yes
2. Do/Did you have/had Pneumonia vaccine? No Yes
3. Do/Did you have/had Flu Vaccine? No Yes
4. Do/Did you have/had Tetanus vaccine? No Yes
5. Do/Did you have/had MMR vaccine? No Yes
6. Do/Did you have/had Varicella (Chicken Pox) vaccine? No Yes



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Name: _____ DOB: _____ Gender M F Date: _____

Social History

1. Are you sexually active: No Yes If no, please move on to question 7

2. At what age did you become sexually active? _____

3. How many sexual partners have you had? _____

4. Do you have any sexual problems? No Yes

5. Have you ever had a sexually transmitted disease? No Yes

6. Which sexually transmitted disease have you had? Other Gonorrhea Herpes Syphilis Chlamydia

7. Do you drink alcoholic beverages? No Yes

8. How often do you drink alcoholic beverages? _____

9. Do you drink caffeinated drinks? No Yes

If yes, how many cups a day _____ ?

10. Are you a smoker? Never Former Current

If you are/were a smoker

How many pack of cigarettes a day ? _____ Yrs smoked _____

11. Do you use or have you used any types of recreational drugs? No Yes

If, yes what kind _____, when discontinued _____



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MEDICAL HISTORY CONT'D

Family History

1. Is your father alive? No Yes

2. Does your father have/had?

 None Heart trouble High BP Stroke TB Cancer Diabetes

3. Is your mother alive? No Yes

4. Does you mother have/had?

 None Heart trouble High BP Stroke TB Cancer Diabetes

5. Do you have siblings? No Yes

6. Does your sibling (s) have?

 None Heart trouble High BP Stroke TB Cancer Diabetes

7. Does your spouse have?

 None Heart trouble High BP Stroke TB Cancer Diabetes

8. Do you have children? No Yes

 If yes, how many? (_____) Sons (_____) Daughters

9. Do your child/children have/had?

 None Heart trouble High BP Stroke TB Cancer Diabetes



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Name: _____ DOB: _____ Gender M F Date: _____

Women Only

1. Date of last menstrual cycle? _____
2. Are you pregnant or is there a possibility that you are pregnant? No Yes
3. If you are pregnant when is your expected due date? _____
4. How many times have you been pregnant? _____
5. How many miscarriages have you had? _____
6. Previous delivery was it Vaginal or C-section
7. When was your last Pap test? _____ Was it Normal Abnormal ?
8. Are you? Menopausal Pre-menopausal Post menopausal
9. Are you on any hormone replacement therapy? No Yes
10. Have you had a mammogram in the past? No Yes If yes, when? _____

MEDICARE PATIENTS ONLY

Functional Ability/Safety Screen

1. Does it take you longer than 30 seconds to get up and go? No Yes
2. Do you need help with the phone, transportation, shopping,
preparing meals, housework, medications or managing money? No Yes
3. Does your home have rugs in the hallway, lack grab bars in the
Bathroom, lack handrails on the stairs or have poor lighting? No Yes
4. Have you noticed any hearing difficulties? No Yes