I-10 Location
12450 East Fwy, Ste. 135
Houston, TX 77015
(713) 222-6374

I-45 Location
5324 North Fwy, Ste. 120
Houston, Texas 77022
(713) 691-8355

Medical History

Patient Name: ______________________________ Date: ______________

Date of Birth: ______________________________ SS# ______ - _____ - ______

Have you ever had any of the following:

#	Condition	Yes	No	#	Condition	Yes	No
01	Severe headache	☐ Yes	☐ No	16	Stomach problems	☐ Yes	☐ No
02	Loss of conscious	☐ Yes	☐ No	17	Black/blood bowels	☐ Yes	☐ No
03	Epilepsy	☐ Yes	☐ No	18	Hernia	☐ Yes	☐ No
04	Dizziness or fainting spells	☐ Yes	☐ No	19	Kidney problems	☐ Yes	☐ No
05	Nervous disorders	☐ Yes	☐ No	20	Arthritis	☐ Yes	☐ No
06	Visual problems	☐ Yes	☐ No	21	Back pain/injury	☐ Yes	☐ No
07	Hearing problems	☐ Yes	☐ No	22	Joint pain or injury	☐ Yes	☐ No
08	Shortness of breath	☐ Yes	☐ No	23	Broken bones	☐ Yes	☐ No
09	Chronic pain	☐ Yes	☐ No	24	Allergies	☐ Yes	☐ No
10	Emphysema	☐ Yes	☐ No	25	Diabetes	☐ Yes	☐ No
11	Asthma	☐ Yes	☐ No	26	Tumor	☐ Yes	☐ No
12	High blood pressure	☐ Yes	☐ No	27	Hepatitis	☐ Yes	☐ No
13	Chest pain	☐ Yes	☐ No	28	Tuberculosis	☐ Yes	☐ No
14	Heart problems	☐ Yes	☐ No	29	Alcohol problems	☐ Yes	☐ No
15	Skin problems	☐ Yes	☐ No	30	Drug Problems	☐ Yes	☐ No

Please explain all "Yes" answers: ____

____

Are you currently under a doctor's care? If yes, explain: ____________________ ☐ Yes ☐ No

Do you smoke? If yes, how much? ____________________ ☐ Yes ☐ No

Are you taking any medication? ☐ Yes ☐ No

If yes, what type? __________ and for what reason? ____________________

Have you ever had surgery? ☐ Yes ☐ No

If yes, what type? __________ and when? ____________________

If female, when was your last menstrual period? ____________________

Do you have menstrual problems? If yes, what type? ____________________ ☐ Yes ☐ No

I hereby certify that all of the above information of the above answers are true to the best of my knowledge.

______________________________________ ______________

Signature Date