Print Form

ANDRES MEDICAL CLINIC

203 South Main Street, PO Box 1470, Anahuac, Texas, 77514 www.andresmedicalclinic.com

Patient Name: _____ D.O.B. _____ Allergies: _____

Have you ever been hospitalized for an illness or had an operation: ☐ Y ☐ N

(If so, give age and reason for hospitalization or operation)

Age _____ Reason _____

Age _____ Reason _____

Age _____ Reason _____

Have you had any serious injuries: ☐ Y ☐ N

Age _____ Reason _____

Age _____ Reason _____

Do you take medication regularly: ☐ Y ☐ N

Medication _____ Medication _____

Medication _____ Medication _____

Medication _____ Medication _____

Medication _____ Medication _____

Are your immunizations up to date: ☐ Y ☐ N

Acne	☐ Y ☐ N	Stomach Ulcer	☐ Y ☐ N	Bladder Infections	☐ Y ☐ N
Asthma	☐ Y ☐ N	Heart Disease	☐ Y ☐ N	Thyroid	☐ Y ☐ N
Diabetes	☐ Y ☐ N	Tuberculosis	☐ Y ☐ N	Alcohol User	☐ Y ☐ N
Chicken Pox	☐ Y ☐ N	Cancer	☐ Y ☐ N	Drug User	☐ Y ☐ N
Mononucleosis	☐ Y ☐ N	Scoliosis/Back Probs	☐ Y ☐ N	Smoker	☐ Y ☐ N
Hepatitis	☐ Y ☐ N	Depression	☐ Y ☐ N	Sex/Emotional Abuse	☐ Y ☐ N
STD's	☐ Y ☐ N	Mood Swings	☐ Y ☐ N	Problems Sleeping	☐ Y ☐ N
Headaches	☐ Y ☐ N	Attempted Suicide	☐ Y ☐ N	Hearing Problems	☐ Y ☐ N
Seizure/Epilepsy	☐ Y ☐ N	Physical Abuse	☐ Y ☐ N	Other	☐ Y ☐ N
Emotional Problems	☐ Y ☐ N	Vision	☐ Y ☐ N		
Sickle Cell Anemia	☐ Y ☐ N	Pregnancy	☐ Y ☐ N		

Do you have any health concerns ☐ Y ☐ N, if so explain

Family information

Please check if anyone in your family have or had any of the following problems

Cancer	☐ Y ☐ N	Drug Use	☐ Y ☐ N	Heart Attack	☐ Y ☐ N
Mental Illness	☐ Y ☐ N	Alcoholic	☐ Y ☐ N	High Blood Pressure	☐ Y ☐ N
Stroke	☐ Y ☐ N	Diabetes	☐ Y ☐ N		