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SOUTH TEXAS RADIOLOGY CENTER

Medical History

Print Name_____ Date _____ Age _____

Email Address: _____

Please check **Y** if you've ever experienced any of the following and **C** if you are currently experiencing any of the following:

Y	C		Y	C		Y	C	
☐	☐	Anemia/Blood disorder	☐	☐	Deep Vein Thrombosis (DVT)	☐	☐	Lupus
☐	☐	Anxiety	☐	☐	Defibrillator/Pacemaker	☐	☐	Metal Implants
☐	☐	Arthritis	☐	☐	Depression	☐	☐	*Phlebitis*
☐	☐	Asthma/emphysema	☐	☐	Double vision	☐	☐	Pigmentation Problems
☐	☐	Atrial Fibrillation	☐	☐	Diabetes	☐	☐	Poor wound healing
☐	☐	Back problems	☐	☐	Dialysis	☐	☐	Pregnant
☐	☐	Bipolar disease	☐	☐	Endometriosis			Number of pregnancies____
☐	☐	Bleeding Problems	☐	☐	Frequent migraines	☐	☐	Breastfeeding
☐	☐	Skin Cancer	☐	☐	Frequent urination	☐	☐	Stroke/TIAs
☐	☐	Other Cancer_____	☐	☐	Glasses/Contacts	☐	☐	Thyroid disorder
☐	☐	Chemo/Radiation	☐	☐	Heart disease	☐	☐	Varicose veins
☐	☐	Chest pain/heart attack	☐	☐	Heart catheterization/Stents	☐	☐	Other:_____
☐	☐	Chronic constipation	☐	☐	Heart valve disorder			
☐	☐	Chronic Obstr Pulm Disease	☐	☐	Hepatitis			
☐	☐	Cirrhosis	☐	☐	High blood pressure			

Which physicians are currently treating you? _____

May we contact them for medical records pertinent to the condition you are being evaluated for today? ☐ No ☐ Yes_____(Initials)

Do you smoke? ☐ Never ☐ No ☐ Yes If yes, how many packs/day ____ How many years? ____ When did you stop smoking? ___

Do you drink alcohol? ☐ Never ☐ No ☐ Yes If yes, how many glasses/day/week/month _____ How many years? _____

Previous Surgeries:

Name of surgery	Date of surgery	Name of surgery	Date of surgery

Allergies:

☐ No known allergies

☐ I am allergic or sensitive to: _____What happens?_____

☐ I develop a rash with use of tape, Band-Aids, latex items

Family Medical History

Mother's History			Father's History		
Health conditions	Current age:	Age at death_____ Cause (es) of death?	Health conditions	Current age:	Age at death_____ Cause (es) of death?

I declare the information provided is true and accurate to the best of my knowledge and will be made a part of my medical record.

Signature of Patient (Parent/Guardian)_____ Date _____

Disclosures to Families and Loved Ones Patient Initials _____

I agree to the release of my PHI to the following person(s) _____

We will comply with any patient's request for us to share their personal health information with family member(s) and other designated person(s). We will comply with an oral request as long as: (1) any oral request is noted in the patient's record; (2) the patient is competent to make this decision; and (3) the patient has not revoked that request.

❒ Permission to Photograph Patient Initials _____

I authorize the staff of the Interventional Radiology Clinic staff to photograph me and affected parts of my body and to include the photographs in my medical record. I agree to the release of the photographs if requested by my *insurance company for* establishing medical necessity of prescribed treatment.

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MEDICATION LIST

Print patient name: _____ Date: _____

Medication List:

Name of prescribed medication, supplement, or over-the counter medication	Dosage amount	Frequency	Prescribed by (name of physician)

Check any of the following medications if you are currently taking them please put name of medication and dosage:

- ❒ Aspirin in any form or amount
- ❒ Advil
- ❒ Aleve
- ❒ Birth Control
- ❒ Blood thinner (Coumadin, Warfarin, Plavix, Lovenox)
- ❒ Heart Medication
- ❒ Hormones
- ❒ Insulin
- ❒ Ibuprofen
- ❒ High Blood Pressure
- ❒ Migraine medication
- ❒ Other: _____

❒ I have read the list of additional medications and am on none of them. _____ (please initial).

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Patient Name: _____ **Date:**_____ **Age:**_____

Patients, please Circle all that apply to you:

General/Constitutional: Unintentional weight loss or gain, fatigue, unable to conduct usual activities, difficulty in exercising

Skin: Rash, itching, pigmentation (discoloration), dryness, poor wound healing, swelling

Breast: Breast lumps, tenderness, swelling, nipple discharge

Head & Face: Frequent headaches or migraines, lightheadedness, injury

Ears: Ringing, hearing loss, ear pain, ear infection, ear drainage, dizziness

Eyes: Double vision, blurry vision, tearing, blind spots, pain

Nose: Nose bleeds, frequent colds, nasal congestion, runny nose, sinus drainage, snoring

Mouth & Throat: Dental difficulties, gingival bleeding, dentures, sore throat, neck stiffness, pain, tenderness, lumps or masses, swollen glands, difficulty swallowing

Heart: Chest pain (angina), high blood pressure, murmurs, irregular rhythms, palpitations, shortness of breath upon exertion, swelling

Lungs: Shortness of breath, wheezing, cough, respiratory infections, fever, night sweats

Gastrointestinal: Abdominal pain, heartburn, nausea, jaundice, constipation or diarrhea, abnormal stools (clay-colored, tarry, bloody, greasy, foul smelling), hemorrhoids

Genitourinary: Urgency, frequency, blood in urine, stones, infections, kidney problems, hesitancy, dribbling, acute retention or incontinence, venereal disease

Female Only: Menstruation: ☐ irregular ☐ heavy ☐ clots; menopause, pelvic pain

Male Only: Prostate problems, scrotal mass, erectile dysfunction

Musculoskeletal: Painful joints, cramps, limited range of motion

Neurologic/Psychiatric: Convulsions, paralyses, tremors, difficulties with memory or speech, previous psychiatric care, hallucinations, anxiety

Blood: Bleeding tendencies, previous transfusions and reactions, Rh incompatibility

Allergies: Reactions to drugs, food, insects, skin rashes, trouble breathing