Dr. CAREing[SM]
411 E. McDermott Drive, Allen, TX 75002,
Phone: 972-227-3464 Fax: 214-295-4450

BRIEF HISTORY

In an effort to serve you better, we request that you provide us with the following information. We need this information to give you the best care and treatment possible. All information is held strictly confidential and is released only with your written consent.

Last name:	First:	Age:	Sex:

ILLNESS/INJURY: Please check if you have:

Yes	No		Yes	No		Yes	No	
		High Blood pressure			Hepatitis			Shortness of breath
		Diabetes			Yellow jaundice			Accidents/broken bones (list)
		Peptic ulcers			Gallstones			
		Heart attack			Kidney stones			
		Chest pain/tightness			Abdominal bleeding			
		History of heart murmur			Diverticulosis			Other:
		Stroke			Thyroid problem			
		Cancer			Lung problems/asthma			

FAMILY HEALTH HISTORY:

OPERATIONS: List names and dates of all operations you have had ☐ None

Year	Name of Operation	Year	Name of Operation

DRUGS: Please list all drugs you take and their dosages. ☐ None

Drug	Dosage	Drug	Dosage
1.		7.	
2.		8.	
3.		9.	
4.		10.	
5.		11.	
6.		12.	

ALLERGIES: Please list type and reaction. ☐ None

Name of Drug	Reaction	Name of Drug	Reaction

Do you now use tobacco? ☐ Yes ☐ No Day # Yrs: _____/_____
Have you ever used tobacco? ☐ Yes ☐ No Yrs quit: __________
Do you drink alcohol? ☐ Yes ☐ No Day # Yrs: _____/_____
Have you ever used alcohol? ☐ Yes ☐ No Yrs quit: __________ Type: ____________________

The above information is true and accurate.

Patient Signature (parent in patient is a minor)____