UTHealth | Medical School
The University of Texas Health Science Center at Houston

NEW PATIENT HISTORY

DR. STEVEN FLORES

Date:	Age: ______ DOB: ____________
Name:	❑ Female ❑ Male
Referring Doctor/Person:	**Height:**________ **Weight:**________
Current Students/School:	Grade:

Current Problem: ❑ Right ❑ Left ❑ Both Date of injury or onset of symptoms:

Briefly Describe:

MEDICAL HISTORY:

CIRCLE if you have ever had any of the following conditions OR CHECK NONE ❑

Angina / Chest Pain	Diabetes (insulin, oral, diet)	Hepatitis A, B or C	Neurological Disorder	Swelling of legs or feet
Asthma	GI Bleed or Ulcer	High Blood Pressure	Psoriasis or Lupus	Thyroid Disease (Hypo or Hyper)
Bleeding Disorder	Gout	HIV / AIDS	Reflux	Cancer
Blood Clot	Heart Disease	Irregular Heartbeat	Rheumatoid Arthritis	Other:
Bowel Disorder	Heart Attack	Kidney Issues	Seizures	
COPD/Emphysema	Heart Murmur	Liver Disease	Stroke / TIA	

PRIOR SURGERIES: If NONE, check here: ❑

	YEAR	COMPLICATION IF ANY

MEDICATIONS:

List medications below, include hormonal therapies (i.e., birth control, testosterone) OR CHECK NONE ❑

MEDICATION	DOSE	HOW OFTEN

PLEASE SEE AND COMPLETE REVERSE SIDE

FEMALES: ❑BIRTH CONTROL ❑HORMONAL THERAPY ❑ CURRENT KNOWN OR POSSIBLE PREGNANT

ALLERGIES: Please list your known **MEDICATION** allergies OR CHECK NONE ❑

MEDICATION	TYPE OF REACTION

Allergy to any of the following?	Yes	No	Type of Reaction
Adhesive or tape			
Eggs			
Iodine or IV Contrast			
Latex			

SOCIAL HISTORY:

Do you currently smoke?	Yes	No	Packs per day?	For how many years?
Alcohol use?	Yes	No	Average number of drinks per week _________	
Recreational or street drugs	Yes	No	Type:	

FAMILY HISTORY:

Do any of the following diseases run in your family? If NONE, check here ❑

Disease	Mother	Father	Siblings	Children
Bleeding Disorders				
Blood Clots				
Cancer (type)				
Heart Attack/Disease				
Stroke				

REVIEW OF SYSTEMS: CIRCLE all of the symptoms you are experiencing **TODAY** OR CHECK NONE ❑

SYSTEM	SYMPTOMS
General Health	Fever, chills, night sweats, weight gain, weight loss
Eyes	Dry eyes, irritation, vision change, double vision
Ears/nose/throat	Hearing difficulty, ear pain, nose/sinus problems, sore throat, bleeding gums, mouth ulcer, teeth abnormalities
Cardiovascular	Chest pain on exertion, arm pain on exertion, shortness of breath with walking or lying down,
Respiratory	Cough, wheezing, short of breath, coughing up blood, sleep apnea
Gastrointestinal	Abdominal pain, vomiting, black stools, frequent diarrhea, vomiting blood, reflux
Genitourinary	Difficulty urinating, increased urinary frequency, blood in urine
Musculoskeletal	Muscle aches, muscle weakness, joint pain, back pain, swelling in extremities
Skin	Jaundice, rash, itching, dry skin, lesions
Neurologic	Loss of consciousness, weakness, numbness, seizure, dizziness, migraines
Psychiatric	Anxiety, depression, sleep disturbance, restless sleep, alcohol abuse
Endocrine	Fatigue, increased thirst, hair loss, hair growth, cold intolerance
Blood System	Swollen glands, easy bruising, excessive bleeding
Allergy/Immunology	Runny nose, sinus pressure, itching, hives

YOUR best contact number:_____________________________ Your Email:____

PATIENTS PLEASE SIGN:____ DATE:___________________________

PHYSICIAN/PA SIGNATURE:____ DATE:___________________________