Patient Medical Information Sheet

Pasteur Medical Associates
Clinical Research, PLLC

4410 Medical Drive, Suite 100
San Antonio, Texas 78229

Patient Name: _____ DOB: _____ Age: _____ Date: _____
Primary Doctor: _____ Referring Doctor/Person: _____
Reason For Today's Visit: _____
_____
_____

Drug Allergies and Reactions

1. _____	3. _____	5. _____
2. _____	4. _____	6. _____

Medical Diseases/Problems/Hospitalizations (for example: diabetes, high blood pressure, depression, glaucoma, etc.)

1. _____	4. _____	7. _____
2. _____	5. _____	8. _____
3. _____	6. _____	9. _____

Surgeries/Operations and Date (for example: open heart surgery, gallbladder, hysterectomy, etc.)

1. _____	4. _____	7. _____
2. _____	5. _____	8. _____
3. _____	6. _____	9. _____

PREVIOUS EVALUATION:
Date of Last physical exam: _____
Recent labs: _____
Recent imaging (X-RAY, CT, MRI, Ultrasound): _____
_____

Men only:
Date of Last prostate exam: _____ Results (normal/abnormal): _____

Women only:
Date of Last pap: _____ Results (normal/abnormal): _____
Date of Last mammogram: _____ Results (normal/abnormal): _____
First day of Last menstrual period: _____
Number of pregnancies: _____ Number of live births: _____

FAMILY HISTORY: does your brother, sister, parents or children have any of the following? (Please check and include what family member(s) have/had each condition)

- ☐ Heart Disease _____
- ☐ Heart Attack _____
- ☐ High Blood Pressure _____
- ☐ Diabetes _____
- ☐ Stroke _____
- ☐ Seizures _____
- ☐ Asthma _____
- ☐ Diverticulosis/-itis _____
- ☐ Irritable Bowel Syndrome _____
- ☐ Gallbladder Stones _____
- ☐ Kidney Stones _____
- ☐ Colon Polyps _____
- ☐ Cirrhosis of Liver _____
- ☐ Celiac Disease _____
- ☐ Blood Disease _____
- ☐ HIV _____
- ☐ Ulcers _____
- ☐ Migraines _____
- ☐ Mental Illness _____

Cancer of:
- ☐ Esophagus _____
- ☐ Liver _____
- ☐ Pancreas _____
- ☐ Stomach _____
- ☐ Colon _____
- ☐ Breast _____
- ☐ Cervix _____
- ☐ Ovaries _____
- ☐ Uterus _____
- ☐ Testicles _____
- ☐ Prostate _____

SOCIAL HISTORY AND HABITS: Please check and give average amounts

Smoke/Chew Tobacco ☐ Yes ☐ No How many years? _____ How many packs per day? _____
Drink Coffee ☐ Yes ☐ No Number of cups/glasses per day? _____
Drink Beer, Wine or Hard Liquor ☐ Yes ☐ No Number of drinks _____ per ☐ Day ☐ Week ☐ Month
Place of Birth: _____ Level of Education: _____
Occupation: _____
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Significant Other's Occupation: _____
Children and Ages: _____

Patient Medical
Information Sheet

Pasteur Medical Associates
Clinical Research, PLLC

4410 Medical Drive, Suite 100
San Antonio, Texas 78229

REVIEW OF SYSTEMS: please check any of the following symptoms or conditions you have had in the last 3 months

CONSTITUTIONAL:	**YES**	**NO**	**EXPLANATION**
Decrease in appetite			
Fever or chills			
Weight change in past 6 months			
EYES:			
Eye pain or redness			
Trouble with vision			
ENT:			
Hoarse voice			
Lump in throat			
Recurrent mouth ulcers			
Sinus drainage			
Sore throat			
CARDIOVASCULAR:			
Heart palpitations or pounding			
Heart problems			
Shortness of breath with exercise			
Shortness of breath with mild activity			
Swelling of feet			
RESPIRATORY:			
Frequent cough			
Phlegm production			
Wheezing or asthma			
GI:			
Abdominal bloating, distension or gas			
Abdominal pain, burning or discomfort			
Black tarry stools			
Bright red blood in stools			
Constipation			
Diarrhea			
Difficulty swallowing			
Fatigue			
Fill up more easily at meals			
Heartburn or indigestion			
Hemorrhoids			
Jaundice			
Nausea			
Vomited blood or "coffee grounds"			
Vomiting			
GENITOURINARY:			
Frequent urination at night			
Pain with urination			
Pain with intercourse			
MUSCULOSKELETAL:			
Arthritis			
Muscle pain			
NEUROLOGICAL:			
Dizzy spells			
Seizures or blackouts			
Headaches			
PSYCHIATRIC:			
Anxiety			
Depression			
HEMATOLOGIC/LYMPH:			
Bleed or bruise easily			

_____ _____

Patient Signature Physician Signature

_____ _____

Date Date