7000 Parkwood Blvd, Ste B200
Frisco, TX 75034

Brett Donahey, D.O.
Phone: 214-705-1900
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Patient's name: ____________________________

New Patient History Form

Your answers on this form will help your health care provider get an accurate history of your medical concerns and conditions. Please fill in as much as you can. If you cannot remember specific details, please provide your best guess. If you are uncomfortable with any question, do not answer it. Thank you!

Main reason for today's visit:____
Other concerns: ____
What are your health goals for the next year? ____
Where were you getting your care before?____

In the past **2 weeks**, have you been bothered by: Little interest or pleasure in doing things? □ **No** □ **Yes**
Feeling down, depressed or hopeless? □ **No** □ **Yes**

Review of Symptoms: Please mark or circle any CURRENT symptoms you have had in the past few days.

General
____Unexplained weight loss / gain
___ Unexplained fatigue / weakness
___ Fall asleep during day when sitting
___ Fever, chills

Skin
___ New or change in mole
___ Rash / itching

Breast
___ Breast lump / pain / nipple discharge

Ears/Nose/Throat
___ Nosebleeds, trouble swallowing
___ Frequent sore throat, hoarseness
___ Hearing loss / ringing in ears

Eyes
___ Change in vision / eye pain / redness

Cardiovascular
___ Chest pain / discomfort
___ Palpitations (fast or irregular heartbeat)

Respiratory
___ Cough / wheeze
___ Loud snoring / altered breathing during sleep
___ Short of breath with exertion

Gastrointestinal
___ Heartburn / reflux / indigestion
___ Blood or change in bowel movement
___ Constipation

Genitourinary
___ Leaking urine
___ Blood in urine
___ Nighttime urination or increased frequency
___ Discharge: penis or vagina
___ Concern with sexual function

Musculoskeletal
___ Neck pain
___ Back pain
___ Muscle / joint pain

Endocrine
___ Heat or cold sensitivity

Hematologic/Lymphatic
___ Swollen glands
___ Easy bruising

Neurological
___ Headache
___ Memory loss
___ Fainting
___ Dizziness
___ Numbness / tingling
___ Unsteady gait
___ Frequent falls

Allergic/Immune
___ Hay fever / allergies
___ Frequent infections

Psychiatric
___ Anxiety / stress / irritability
___ Sleep problem
___ Lack of concentration

Women only
___ Pre-menstrual symptoms (bloating cramps, irritability)
___ Problem with menstrual periods
___ Hot flashes / night sweats

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IMMUNIZATIONS: Check off any vaccinations you have had. Add year, if known. Check the box if you don't know the information. ☐

Tetanus (Td) ______ With Pertussis (Tdap) _______ Varicella (Chicken Pox) shot *or* illness ______

Pneumovax (pneumonia) _____ Influenza (flu shot) _____ Hepatitis A _____ Hepatitis B _____ MMR _____

Meningitis _____ Zostavax (shingles) _____ HPV _____

MEDICATIONS: Please list (or show us your own printed record) all prescriptions and non-prescription medications, vitamins, home remedies, birth control pills, herbs, inhalers, etc. Use the back of this form if you need more room and let us know you wrote there.

☐ TAKE NO MEDICATIONS

Name of Medication	Dosage and frequency	Start date

Personal Medical History: check the box if you have or have had any of the following health conditions and list the date if possible:

Alcohol/drug abuse		Chicken pox		Cataracts	
Anemia		Cancer		Blood transfusion	
Arthritis		Coronary Artery Disease		Glaucoma	
Asthma		Depression		Gout	
Allergy		Diabetes (adult onset)		Endometriosis	
Anxiety		Diabetes (childhood onset)		Fibroids	
Bladder/kidney problems		Diverticulosis		Heart attack	
Blood clot leg		Emphysema		Hepatitis A	
Blood clot lungs		Fractures		Hepatitis B	
Breast lump		Gallbladder disease		Hepatitis C	
High blood Pressure		Gastro-esophageal reflux/ heart burn		Pneumonia	
High Cholesterol		Kidney Stones		Prostate enlargement or nodules	
Hip fractures		Liver Disease		Seizures/epilepsy	
Irritable Bowel Syndrome		Migraine Headaches		Eczema/psoriasis	
Kidney Disease/Failure		Osteoporosis		Abnormal moles	
Sleep apnea		Stomach ulcer		Stroke	
Thyroid problems					

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Personal Surgical History:

____
____
____
____

OTHER HEALTH ISSUES:

Tobacco Use Smoke cigarettes: □ Never □ No □ Yes

(If you never smoked please go to alcohol use question now) Quit date: ______ How many years did you smoke? _______ Approximately how many packs a day did you smoke? _______ Current smoker: Packs/day: _________ # of years: _________ Other tobacco: □ Pipe □ Cigar □ Snuff □ Chew

Alcohol Use Do you drink alcohol? □ No □ Yes # of drinks/week: ___________ □ Beer □ Wine □ Liquor

Drug Use Do you use marijuana or recreational drugs?
□ No □ Yes

Have you ever used needles to inject drugs? □ No □ Yes

Allergies or intolerance to medications (include type of reactior
____
______________________________________ □ NONI

HEALTH MAINTENANCE SCREENING TESTS:
Lipid (cholesterol) Abnormal? Yes No
Colonoscopy or Sigmoidoscopy? Yes No _________ dat
Polyp? Yes No
Women only. Mammogram? Yes No __________ date
Abnormal? Yes No
Women only: Pap Smear? Yes No ________ date
abnormal? Yes No
Women only: Bone Density? Yes No ___________date
abnormal? Yes No

Have you completed an Advance Directive for Health Ca (ADHC), Living Will, or POLST (Physician Orders for Life Sustaining Therapy)? Circle all the apply

Family History:

Stroke: ______________________ Heart Attack: ______________________

Diabetes: ______________________ Cancer: ______________________

Other: ______________________