

FUQUA FAMILY PRACTICE AND URGENT CARE

10655 FUQUA #C HOUSTON, TX 77089 PHONE: 713-941-1566 FAX: 713-941-1577

HEALTH HISTORY: Check (X) Symptoms You Currently Have or Have Had In The Past Year.

General: Chills Fever Weight Loss Decline In Health Weakness Fatigue
 Weight Gain

Head: Dizziness Headaches Fainting Pain Head Injury

Eyes: Blurry Vision Double Vision Eyeglass Use Pain with Light Unusual Sensations
 Cataracts Excessive Tearing Glaucoma Recent Injury Vision Loss Discharge
 Eye Pain Eye Infections Eye Redness

Ear, Nose, Throat: Nose Discharge Nose Infections Sinus Infections Frequent Colds
 Nasal Obstruction Hay Fever Nosebleeds Bleeding Gums Postnasal Drip
 Changes in Dentition Tongue Biting Hoarseness Voice Changes Ear Discharge
 Hearing Impairment Ringing in Ears Dizziness Ear Infections Hearing Aid
 Ear Pain Frequent Sore Throats Tonsils Enlarged Neck Lump Neck Tenderness

Respiratory: Asthma Bronchitis Inflammation of Membrane Surrounding Lung
 Short of Breath Coughing Blood Cough Positive for Tuberculosis Sputum Wheezing
 Pain with Deep Breath Recent Chest X-ray Tuberculosis

Cardiovascular: Chest Pain Arms/Legs feel Cold Heart Murmur History of Heart Attack
 Rheumatic Fever Short of Breath while Sleeping Palpitations Discolored Extremities
 History of Heart Tests(Not EKG) Leg Pain w/ walking Short of Breath w/ Exertion
 Swelling of Legs Varicose Veins Hair Loss on Legs High Blood Pressure
 Recent Electrocardiogram Short of Breath while Lying Flat Inflammation of Vein w/Clot

Psychiatric: Depression Disturbing Thoughts Memory Loss Psychiatric Disorders
 Behavioral Changes Excessive Stress Mood Changes Disorientation Hallucinations
 Nervous

Breasts: Discharge Self-Examination Lumps Tenderness Breast Pain



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Gastrointestinal: Abdominal Pain Heartburn Rectal Bleeding Black Tarry Stools
 Change in Stool Color Excessive Hunger Hemorrhoids Laxative Use Swallowing Problems
 Constipation Jaundice Abdominal X-ray Tests Change in Frequency of Bowel Movement
 Change in Stool Consistency Excessive Thirst Hepatitis Nausea Vomiting Diarrhea
 Liver Disease Antacid Use Change in Stool Shape Decreased Appetite Gallbladder Disease
 Stomach Infections Rectal Pain Vomiting Blood

Musculoskeletal: Arthritis Back Problems Muscle Cramps Restricted Motion
 Joint Pain Muscle Deformities Muscle Stiffness Weakness Gout Joint Stiffness
 Paralysis

Skin: Eczema Easy Bruisability Hives Nail Appearance Change Skin Color Change
 Itching Hair Dye Skin Lumps Nail Texture Change Dryness Hair Texture Change
 Mole Increased Size Rashes

Neurological: Loss of Consciousness Dizziness Headaches Paralysis Tingling
 Blackouts Fainting Memory Loss Speech Disorders Tremors Burning
 Head Injury Numbness Strokes Unsteady Gait

Endocrine: Weakness Cold Intolerance Goiter Neck Pain Weight Gain
 Excessive Urination Heat Intolerance Sweats Weight Loss Fatigue Increased Thirst
 Thyroid Trouble

Hematologic: Anemia Easy Bruisability Swollen Glands Bleeding Easily Lumps
 Transfusion Reaction Blood Clots Radiation Exposure

Allergic/Immunologic: Cough Itchy Eyes Runny Nose Watery Eyes
 Coughing with Exercise Itchy Nose Sneezing Wheezing Hives Recurrent Infections
 Stuffy Nose Wheezing with Exercise

Genitourinary: Awakening to Urinate Burning with Urinating Back Pain
 Urinary Infections Kidney Stones Strong Urine Odor Bed-Wetting
 Difficulty Starting Stream Urinating Frequently Pain with Urination Urgency
 Blood in Urine Excessive Urination Incontinence Retention Urine Discoloration

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Please list any additional symptoms not listed above: _____

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Please list any new medications since last visit with dosage and frequency.

Medication Name(ex.Norvasc)	Dosage(ex.5mg)	Frequency(ex.Once daily)	Reason for Use(ex.Blood Pressure)
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1. _____	_____	_____	_____
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2. _____	_____	_____	_____
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3. _____	_____	_____	_____
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Please list any recent surgeries since last visit.

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Signature:

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please Print Name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient

Reviewed By

Date