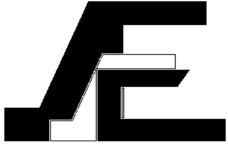

Sunset Clinic, PA

1922 w 10th, Dallas, TX, 75208;
Tel: 214-942-3113;
web: sunsetclinicdfw.com

To help us better evaluate your health, please complete this form to the best of your knowledge before your first appointment. *Our staff will be available to assist you with any questions. Everything is* ***CONFIDENTIAL*** *and part of your medical record.*

Name:

Date of birth:	**Visit date:**

Reason for visit:

CURRENT SYMPTOMS

Any pain? ◯ Yes ◯ No | If yes, how severe? ◯ mild (1-3) ◯ moderate (4-6) ◯ severe (7-10)

Where is the pain?

CURRENT MEDICAL ISSUES: Have you recently had any of the following...

CONSTITUTIONAL	**YES**	**NO**	**EYES**	**YES**	**NO**
Any recent weight change			Vision change in past 6 months		
Fatigue > 6 months			Wear glasses / contact lenses		
CARDIOVASCULAR			**EARS / NOSE / THROAT**		
Chest pain			Change in hearing in past 6 months		
Palpitations / irregular heart beat			Voice change		
Cannot climb 2 flights of stairs			Frequent nose bleeds		
RESPIRATORY			**GASTROINTESTINAL**		
Chronic / frequent cough			Nausea / vomiting		
Wheezing			Abdominal pain		
Shortness of breath			Change in bowel habits		
MUSCULOSKELETAL			**GENITOURINARY**		
Painful / swollen joints			Blood in urine		
Difficulty walking			Difficulty holding urine		
NEUROLOGICAL			**PSYCHIATRIC**		
Frequent headaches			Feeling depressed / sad lately		
Memory problems			Nervous / anxious		
ENDOCRINE			Suicide attempt		
Any loss in height			**SKIN**		
Excessive thirst / urination			Hair loss / excess hair growth		
FOR WOMEN ONLY			Rashes / itching		
Abnormal vaginal discharge / bleeding			***FOR MEN ONLY***		
Lump in breast / nipple discharge			Discharge from penis		
History of abnormal PAP Smear			Lump on testicles		
Pregnancies					

PAST MEDICAL HISTORY	YES	NO
High blood pressure		
Heart disease		
High cholesterol		
Diabetes		
Stroke / seizure		
Arthritis		
Asthma / obstructive lung disease		
Thyroid disease		
Cancer		
Depression / anxiety		
Sexually transmitted diseases		
Alcohol / drug abuse		
ADULTS (65 years of age and older)		
Able to dress alone		
Able to eat alone		
Able to walk alone		
Maintain own hygiene		
Able to shop alone		
Able to do housekeeping		
Able to cook		
Able to manage money		
Use phone / transportation		
Feel safe at home		
Any home care service		
Living will or health care proxy		
Other issues:		

SOCIAL HISTORY		
Past / present smoker		
Past / present alcohol abuse		
Physical / verbal / sexual abuse		
Wear seat belts		
Able to pay for meds		
Live alone		
Any social support		
Any religious concerns		
Any cultural concerns		
Level of education: o grade school o H.S. o college		
Occupation:		
Other:		

HEALTH MAINTENANCE	YES	NO
Tetanus vaccine		
Pneumonia vaccine		
Influenza vaccine		
Pap smear		
Mammogram		
Bone density study		
Colonoscopy		
Dental examination		
Eye examination		
PPD (TB Test)		
ALLERGIES		
Allergies to food / medicine?		
Reaction:		

MEDICATION

Please list medications you are currently taking (include vitamins, herbals).

Name	Dosage	Frequency

ACKNOWLEDGEMENT

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I need.

Signature of Patient/ Guardian

Name (Print):

DOB:

Above information reviewed and confirmed with patient.

Physician's signature

Physician's Name (Print):

Date: