austin concierge medicine

SIDNEY T. ROBIN, M.D.
FAMILY PRACTICE

Date:_____

ADULT DATABASE

Name: _____ **Sex**: ____ **Date of Birth**: _____ **Age**:_____
Last First Initial

Past Medical History

	YES	NO		YES	NO
Heart Disease	☐	☐	Diabetes	☐	☐
Kidney Disease	☐	☐	Thyroid or Glandular	☐	☐
Asthma & Lung	☐	☐	Cancer	☐	☐
Liver, Hepatitis	☐	☐	Back or Spine Disorder	☐	☐
Gastrointestinal	☐	☐	Rheumatic Fever	☐	☐
Peptic Ulcer	☐	☐	Stroke	☐	☐
Head Injury, Seizures	☐	☐	Migraines	☐	☐
Psychiatric Disorder	☐	☐	Colon Disorder	☐	☐
High Blood Pressure	☐	☐	HIV or AIDS	☐	☐

List ALL Hospitalizations & Surgeries (with dates)

TYPE	YEAR	TYPE	YEAR
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Allergies:

MEDICATION	REACTION
_____	_____
_____	_____
_____	_____
_____	_____

Immunizations (with dates):

Tetanus, Diphtheria (Td): _____ **Tetanus, Diphtheria, Pertussis (Tdap):** _____
Zostavax (shingles): _____ **Pneumovax (pneumonia):** _____
Hepatitis A: _____ **Hepatitis B:** _____

PLEASE COMPLETE OTHER SIDE

GYN (Women Only) Pregnancies _____ Full Term _____ Premature _____ Still Born _____ Abortion/Miscarriage _____

Age Menses Began _____ Hysterectomy Yes ☐ No ☐ Last Menstrual Period_____

SOCIAL HISTORY:

Tobacco use? Yes ☐ No ☐ / If yes, what type? _____ How Much Per Day?_____ For How Long? _____

If used to, how much? _____ How long? _____ When did you quit? _____

Do you drink alcoholic beverages? Yes ☐ No ☐ How many drinks a week? _____

Highest Level of Education? _____ Occupation? _____

Exposure to toxic chemical, work related injuries or stresses? _____ Military Service? _____

Foreign Travel (Where?) _____

Do you wear seat belts? Yes ☐ No ☐ Exercise Type & Schedule?_____

Hobbies? _____

FAMILY HISTORY:

PARENTS	**HEALTH STATUS:**	**IF DECEASED - CAUSE OF DEATH**	**AGE**
Father	GOOD FAIR POOR	_____	_____
Mother	GOOD FAIR POOR	_____	_____
SIBLINGS			
_____	GOOD FAIR POOR	_____	_____
_____	GOOD FAIR POOR	_____	_____
_____	GOOD FAIR POOR	_____	_____
_____	GOOD FAIR POOR	_____	_____
CHILDREN: MALE/FEMALE			
____	GOOD FAIR POOR	_____	_____
____	GOOD FAIR POOR	_____	_____
____	GOOD FAIR POOR	_____	_____

Please list any family members with the following diagnoses (please specify *paternal*/*maternal*):

Cancer: _____
Heart Disease: _____
Diabetes: _____
High Blood Pressure: _____
Stroke: _____
Rheumatoid Arthritis: _____
Gout: _____
Glaucoma: _____
Migraines: _____
Asthma/Lung Disease: _____
Colon Disease: _____ Peptic Ulcer: _____
Alcohol/Drug Abuse: _____ Hereditary Disorder: _____
Mental Illness: _____ Blood Disease: _____
Epilepsy: _____ Kidney Disease: _____
Sickle Cell Anemia: _____ Tuberculosis: _____

The above is complete and true to the best of my knowledge. I, the undersigned, voluntarily consent and grant permission to the physician to perform tests, treatments and procedures as indicated for myself or the above named minor for as long as I am a patient of the physician.

_____ _____ _____ _____

Patient's Signature Date Reviewed by Date

Submit