G. DeAn Strobel, MD, PA

Hormonal Balance & Wellness

G. DeAn Strobel, MD * Susan Lee Fisher, PA-C * Brooke Lipscomb, PA-C * Angelica Ortiz, NP 230 East Evergreen Street * Sherman, TX 75090 * Phone: (903) 957-0275 * Fax: (903) 957-0279

ESTABLISHED PATIENT INTERVAL MEDICAL HISTORY FORM

Name _____ Birthdate _____Today's date: _____

Primary Care Physician: _____ Are you (please circle one): Married Single Divorced Widowed Separated

Do you: Smoke? YES or NO If yes, how many packs per day _____ # Years smoked _____
Drink Alcohol? YES or NO If yes, how many drinks per day? _____
Drink soda/coffee/tea? _____ How many per day? _____
Use artificial sweeteners? _____ How much per day? _____
Do you have problems with milk or dairy products? YES or NO Other foods? _____

List the prescription and over-the-counter medications you are now taking:

_____ _____ _____

_____ _____ _____

List any supplements, herbs or vitamins that you are taking:

_____ _____ _____

_____ _____ _____

Are you interested in weight loss? If so, please list all medications, products that you have tried in the past and how they worked for you. Also, list any special diets or meal plans that you have tried in the past.

_____ _____ _____

_____ _____ _____

List any allergies you have to drugs, food or other items:

_____ _____ _____

_____ _____ _____

Are you currently under medical care at any other offices for any reasons? If yes, please explain: _____
_____
_____
_____
_____

WOMEN ONLY:

Age when menstrual periods began _____
Are your periods regular? _____ How Often? _____
How many days do your periods last? _____
How many times have you been pregnant? _____
How many children born alive? _____
Are you menopausal? YES or NO If yes, did this occur NATURALLY or SURGICALLY? And at what age? _____

Past Psychiatric/Mental Health Care:

Therapist's Name: _____ For How Long and When: _____

G. DeAn Strobel, MD, PA

Hormonal Balance & Wellness

G. DeAn Strobel, MD * Susan Lee Fisher, PA-C * Brooke Lipscomb, PA-C * Angelica Ortiz, NP 230 East Evergreen Street * Sherman, TX 75090 * Phone: (903) 957-0275 * Fax: (903) 957-0279

List operations performed since your last visit with us:

Operation Performed	Year	Hospital	Doctor
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List all times you have been admitted to a hospital overnight (except for childbirth) since your last visit with us

Reason Hospitalized	Year	Hospital	Doctor
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please check if any relative (parents, siblings, grandparents, children) have been diagnosed with:

High blood pressure:	_____	Kidney Disease:	_____	Asthma:	_____
Stroke:	_____	Bleeding Tendencies:	_____	Tuberculosis:	_____
Cancer:	_____	Seizures:	_____	Colitis:	_____
Emphysema:	_____	Heart Disease:	_____	Anemia:	_____
Ulcers:	_____	Sugar Diabetes:	_____	Gout:	_____
Mental Illness:	_____	Other Serious Illness:	_____		

Have you had or been diagnosed with any of the following illnesses or conditions: (Please Circle or Highlight)

Measles	Diabetes	Typhoid	Chronic constipation/diarrhea
Rubella (German Measles)	Goiter/Thyroid Disease	Malaria	Ulcerative colitis/Crohn's
Chickenpox	Hives	Other Tropical Diseases	Rheumatoid arthritis
Mumps	Allergies	Hepatitis	Hashimoto's thyroiditis
Whooping Cough	Eczema	Venereal Disease/STI	Osteopenia/osteoporosis
Scarlet Fever	Mono	Seizures	Stroke/TIA
Tonsillitis	Rheumatic Fever	Meningitis	Blood clot/DVT/pulmonary embolism
Diphtheria	Poliomyelitis	Ear Infections	Fibrocystic breast disease
Asthma	Pleurisy	Heart Murmur	Endometriosis
Glaucoma	Bronchitis	High Blood Pressure	Uterine fibroids
Cancer	Influenza	Low Blood Pressure	Migraine headaches
Angina Pectoris/Chest Pain	Tuberculosis	Heart Attack	Infertility
Ulcer	Phlebitis	Kidney Stones	Low hormones/low testosterone
Bladder or Kidney Infection	Depression/anxiety	Heart stent	Heart arrhythmia

Other serious illnesses: (Please Explain):

_____

_____

G. DeAn Strobel, MD, PA

Hormonal Balance & Wellness

G. DeAn Strobel, MD * Susan Lee Fisher, PA-C * Brooke Lipscomb, PA-C * Angelica Ortiz, NP 230 East Evergreen Street * Sherman, TX 75090 * Phone: (903) 957-0275 * Fax: (903) 957-0279

Please list the date and results (if known and if applicable) of your last:

Bone Density Scan: _____Date:_____

Mammogram: _____ Date:_____

X-ray: _____ Date:_____

EKG: _____Date:_____

Blood Count: _____Date:_____

Cholesterol: _____ Date:_____

Blood chemistry: _____ Date:_____

Date of last examination by a doctor: _____ Doctor _____ Results:_____

_____

We like to communicate with your other doctor(s) from time to time to keep them abreast of any changing medical conditions and medications as well as to send them various test and lab results. Please list all of your current doctors, as appropriate.

Primary care provider (PCP): _____Gastroenterologist (GI): _____

Cardiologist (heart): _____ Pulmonologist (lung): _____

Surgeon: _____ Podiatrist: _____

Dentist: _____ Rheumatologist: _____

Some of our patients come to our clinic for specific concerns while others prefer to have most of their medical needs performed here.

Will you be having your routine wellness exams with another provider? YES or NO? If so, who? _____

Do you currently keep up-to-date on your vaccinations? If not, why not? _____

If so, please list the date of your most recent: Tetanus _____ Flu _____ Pneumonia _____ Shingles _____

If you are under the age of 26, have you received the Gardasil or HPV vaccine? YES or NO?

It should be noted that medications may have unwanted side effects. You are strongly urged to bring to our attention any problem that you may be having with your medications. It is also very helpful for you to bring ALL medications (prescription and over-the-counter) as well as supplements and vitamins with you to your appointments.

_____

Patient Signature Date