1 Year LAB Update

Larry A. Richardson, M.D., P.A.

1230 Rayford Bend
Spring, TX 77386
281-292-2300

To be completed by staff

BMI _____ % Body Fat_____

Date: _____
Of Appointment

MEDICAL HISTORY QUESTIONNAIRE

Do **NOT** leave any questions **BLANK**

CONTACT via EMAIL ☐ **Y** ☐ **N**

Email: _____

Social Security No.: _____ Driver's License No.: _____ State: _____
(MUST HAVE)

Name: _____ Sex: _____ Age: _____ DOB: _____
Last First Middle Mo/Day/Yr.

Address: _____ City: _____ State: _____ Zip: _____

Mailing Address for correspondence from this office: (if different) _____

Phone: Home: (___) _____ Work: (___) _____ Marital Status: Sgl Mar Wid Div Se

Cell: (___) _____ E-mail: _____

Occupation: _____ Employer: _____

Spouse's Name: _____ Phone: (___) _____ Employer: _____

Alternate Contact: Name/Address: _____ Phone: (___) _____

Relative's Name/Address: _____ Phone: (___) _____

Family Physician: _____ Date Physician Last Seen: _____ Reason: _____

ALLERGIES TO MEDICATION: _____

Write "NONE" if no medication allergies

Please check any of the following medications you are presently taking and list drug and dosage

- ☐ Birth Control Pills, Patches, Shots, IUDS _____
- ☐ Hormones (include shots) _____
- ☐ Allergy Sinus Medication (include shots) _____
- ☐ Fluid/Water Pill _____
- ☐ Insulin or other Diabetic Medications _____
- ☐ Over the Counter Medications _____
- ☐ Vitamins, Herbs _____
- ☐ **Present Medications not listed above (include dosage if known)** _____

GENERAL (Check Appropriate Box)

Y	N	
☐	☐	Alcohol use
☐	☐	Beer, whiskey, Wine, Cocktail – Amt _____ per week
☐	☐	Emotional/Social Problems (including sexual)
☐	☐	Prior use marijuana, cocaine, amphetamines. When? _____
☐	☐	**SMOKE** (circle): Cigarettes, Cigar, Pipe – Amt _____
☐	☐	Coffee/Tea/Colas: _____cups/oz. per day
☐	☐	Exercise Regularly _____ type
☐	☐	Recent weight change _____lbs. lost/gained

Rate your General Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Rate your Physical Fitness: ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Rate your Mental State: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Self & Family Status

Health Status (Check if positive / yes)	**Self**	**Parents**	**Brothers Sisters**
Cancer……	☐	☐	☐
Diabetes……	☐	☐	☐
Epilepsy or Blackouts…….	☐	☐	☐
Glaucoma ……	☐	☐	☐
Heart Attack (MI)……	☐	☐	☐
High Blood Pressure……	☐	☐	☐
Liver Problems / Hepatitis…..	☐	☐	☐
Migraines……	☐	☐	☐
Stroke……	☐	☐	☐
Thyroid Problems……	☐	☐	☐

☐ **Check here if none of the ABOVE apply to you**

HISTORY OF MEDICAL PROCEDURES AND HOSPITALIZATIONS

	Comments	**Date**
List Previous Hospitalizations or surgeries	_____	_____
	_____	_____
	_____	_____

REVIEW OF SYSTEMS

For this section, please check ANY problem you have had. WRITE IN THE LAST TIME YOU EXPERIENCED that problem NEXT TO the item checked AND how frequently that problem (I.e. none, currently, daily, weekly, monthly, yearly, etc.). Please include this information, AS WELL AS when the problem checked started AND how it is being treated (if it is being treated)

CENTRAL NERVOUS SYSTEM

- ☐ Excessive moodiness/PMS
- ☐ Fatigue
- ☐ Depression
- ☐ Seizures
- ☐ Blackouts
- ☐ Shakiness/nervousness
- ☐ Fainting Spells
- ☐ Headaches
- ☐ Tingling
- ☐ Double vision
- ☐ Dizziness
- ☐ Blurred Vision
- ☐ Difficulty Sleeping
- ☐ Numbness
- ☐ Other _____

SENSORY SYSTEM

- ☐ Nosebleeds
- ☐ Sore throats-frequent
- ☐ Swallowing problem
- ☐ Hoarseness
- ☐ Ringing in ears
- ☐ Other _____
- ☐ Hearing Loss
- ☐ Sinusitis/Sinus Congestion

CIRCULARTORY/RESPIRATORY SYSTEM

- ☐ Angina/chest pain
- ☐ Swollen ankles or feet
- ☐ Previous heart attack
- ☐ Irregular pulse
- ☐ Shortness of breath
- ☐ Heart murmur
- ☐ Leg pain with walking
- ☐ Bruise easily
- ☐ Pleurisy
- ☐ Rheumatic fever history
- ☐ Anemia; Varicose veins
- ☐ Palpitations (fast beats)
- ☐ Cold numb feet
- ☐ Asthma; Emphysema
- ☐ Other _____

DIGESTIVE SYSTEM

- ☐ Ulcer
- ☐ Abdominal pain - chronic
- ☐ Irritable bowel/colitis
- ☐ Indigestion/heartburn
- ☐ Hiatal hernia
- ☐ Gall bladder trouble
- ☐ Diverticulitis
- ☐ Constipation
- ☐ Stomach ache
- ☐ Diarrhea (Chronic)
- ☐ Hemorrhoids (piles)
- ☐ Other _____

GENITO-URINARY SYSTEM

- ☐ Currently on dialysis
- ☐ Stones (Calculi)
- ☐ Difficult/painful urination
- ☐ Decrease in force of urine
- ☐ Kidney removed or missing
- ☐ Trouble with urine control
- ☐ Excess urination (day/night)
- ☐ Sugar, albumin, or pus in urine
- ☐ Other _____

MUSCOLO-SKELETAL SYSTEM

- ☐ Joint pain (Where: _____)
- ☐ Arthritis
- ☐ Back pain
- ☐ Muscular aches or cramps
- ☐ Weakness of hands/legs/feet
- ☐ Muscle jerking
- ☐ Gout
- ☐ Joint swelling (Where:_____)
- ☐ Other _____

INTEGUMENTARY SYSTEM

- ☐ Change in Skin
- ☐ Rash
- ☐ Change in hair (Describe)
- ☐ Other _____
- ☐ Polyp/Tumor/Cancer

(Where: _____)

FEMALES ONLY

	Y	N		Y	N
Currently nursing a baby?	☐	☐	Regular menstrual cycle if no, what problems do you have: _____	☐	☐

REMINDER: Did you remember to list last occurrence/frequency of all problems checked above?