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.: ______________________________ (MUST HAVE) Driver's License No.: ______________________________ State: _________________

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 ☐ Shakiness/nervousness ☐ Dizziness
☐ Fatigue ☐ Fainting Spells ☐ Blurred Vision
☐ Depression ☐ Headaches ☐ Difficulty Sleeping
☐ Seizures ☐ Tingling ☐ Numbness
☐ Blackouts ☐ Double vision ☐ Other ___________________

SENSORY SYSTEM

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

CIRCULARTORY/RESPIRATORY SYSTEM

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

DIGESTIVE SYSTEM

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

GENITO-URINARY SYSTEM

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

MUSCOLO-SKELETAL SYSTEM

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

INTEGUMENTARY SYSTEM

☐ Change in Skin ☐ Change in hair (Describe) ☐ Polyp/Tumor/Cancer
☐ Rash ☐ Other __________________ (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?