

MEDICAL HISTORY

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Last First Middle

Family Physician: \_\_\_\_\_  
Name City Area Code + Phone Date of Last PHYSICAL

**Effective 01 SEP 2025: Texas S.B. 1188 mandates we MUST ask the following:**

Biological Sex at Birth (circle one) M F Any diagnosed sexual development disorders? (circle one) Yes No

If yes, please explain: \_\_\_\_\_

Note: Changes are only allowed for clerical error or a verified disorder of sexual development. Changes require medical documentation.

.....  
 Please **CIRCLE** the appropriate answers.

Do you or have you ever had any of the following medical conditions?

Arthritis (any type)	Yes	No
Artificial Heart Valves or Joints	Yes	No
Asthma or any Breathing Disorders	Yes	No
Bleeding or Blood Disorders	Yes	No
Blood Transfusions	Yes	No
Cancer / Tumors / Chemotherapy	Yes	No
Diabetes	Yes	No
Fainting / Epilepsy / Seizures	Yes	No
GI disorders, e.g. Celiac, Crohn's	Yes	No
Heart Murmur / other heart defect	Yes	No
Heart Surgery (any type)	Yes	No
Hepatitis (any type)	Yes	No
HIV+ or AIDS	Yes	No
Leukemia	Yes	No
Liver / Kidney / other organ problems	Yes	No
Low / High Blood Pressure	Yes	No
Lupus	Yes	No
Osteoporosis / any bone disorders	Yes	No
Radiation Treatment	Yes	No
Rheumatic / Scarlet Fever	Yes	No
Stroke	Yes	No
Thyroid Disorders	Yes	No
Tuberculosis	Yes	No
Venereal Disease	Yes	No

Please write any other unlisted medical condition(s) that you have / had:  
 \_\_\_\_\_

Are you under a physician's care for any reason? Yes No

If yes, please explain:  
 \_\_\_\_\_  
 \_\_\_\_\_

Are you currently using ANY pills, medications, herbal, homeopathic or natural remedies, or any illicit drugs? Yes No

If yes, please list type and dosage, if needed use back of form:  
 \_\_\_\_\_  
 \_\_\_\_\_

\*\*\*\*\*

Do you use ANY tobacco products? Yes No

Have you used or use E-cigarettes, e.g. vaping? Yes No

Have you used or use medical marijuana? Yes No

If yes to any previous questions, please describe use:  
 \_\_\_\_\_  
 \_\_\_\_\_

\*\*\*\*\*

Do you have any learning or speech disabilities? Yes No

If yes, please explain: \_\_\_\_\_  
 \_\_\_\_\_

**FOR PATIENTS UNDER 18 YEARS OF AGE**

Current height: \_\_\_\_\_ Current weight: \_\_\_\_\_

Updated height: \_\_\_\_\_ Updated weight: \_\_\_\_\_

**FEMALES ONLY**

Are you or do you think you're pregnant? Yes No

If yes, how far along are you? \_\_\_\_\_

Are you taking any type of birth control? Yes No

If yes, what type? \_\_\_\_\_

If you're currently age 16 or younger:  
 What age was onset of menses? \_\_\_\_\_

MY SIGNATURE BELOW INDICATES THAT I HAVE COMPLETED THIS FORM TO THE BEST OF MY KNOWLEDGE.

Signature: \_\_\_\_\_  
(Parent, Legal Guardian, or Adult Patient only)

Date 1: \_\_\_\_\_ Date 2: \_\_\_\_\_