TEXAS
INFECTIOUS DISEASE
INSTITUTE

INITIAL PATIENT ASSESSMENT & HISTORY

Patient Name | Date of Birth

Age | Sex

(MD)
Referred by

(MD)
Primary Care/Family Physician

HISTORY & PAST ILLNESS

Main Reason for Visit

PAST MEDICAL HISTORY

(Circle one)			Comments
Yes	No	Diabetes / Diabetic Complications	______
Yes	No	High Blood Pressure	______
Yes	No	HIV	______
Yes	No	Cancer	______
Yes	No	Kidney Disease	______
Yes	No	Lung Disease	______
Yes	No	Auto-Immune Disease	______
Yes	No	Weight Loss	______

PAST SURGICAL HISTORY

Previous Surgery (Circle One) Yes No If yes, type of surgery and date performed

Date / Procedure ______

Date / Procedure ______

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SOCIAL HISTORY

Marital Status (Circle One) Single Married Divorced Widowed

Number of Children ______________ Are you currently employed? Yes No

What kind of work do you do? ______________________________

Do you smoke? (Circle One) Yes No

If yes, how much? ______________ How long have you smoked? ______________

Have you ever been in AA (Alcoholics Anonymous) or any other type of rehab program?

(Circle One) Yes No If yes, when? ______________

PSYCHIATRIC HISTORY

Do you suffer from depression and/or anxiety? ______________________________

Are you currently under the care of a psychiatrist? ______________________________

Have you ever been admitted to a hospital or institution for psychiatric reasons? ______________

If yes, when? ______________________________

MEDICATIONS

Please list all medications you are currently taking, including all over-the-counter medications.

Medication Name / Dosage / Frequency

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

ALLERGIES

Are you allergic to any medications? (Circle One) Yes No Unknown

Do you have environmental or food allergies? (Circle One) Yes No Unknown

Allergy	Type of Reaction