

Past Medical Health History

Date _____

Name _____ Birthdate ___/___/___ Age _____ Occupation _____

Single: ___ Married # of children: _____ Year(s) Born: _____

Vaginal Delivery or C-section? _____ # Miscarraiges: ___ #of Terminations: _____

MEDICATION ALLERGIES: _____

WHAT PRESCRIPTION OR OTC MEDS DO YOU TAKE? _____

VITAMINS OR SUPPLEMENTS OR HERBALS? _____

WHAT OTHER TREATMENTS DO YOU GET? _____

What other doctors do you see? _____

What are your concerns today? General Wellness Exam Other (mark below or describe further at page bottom)

Current and Past Medical History C = Current P = Past Please mark boxes appropriately

C	P		C	P		C	P	
		Heart Disease			Allergies			Marijuana/street drugs
		Blood Clots/Thromophlebitis			Cancer _____			Anxiety/Panic attacks
		Stroke			Liver problems			Depression
		High Blood Pressure			Anemia			Bipolar Disorder
		Mitral Valve Prolapse			Kidney Disease			Psychotic Disorder
		Heart Murmur			Asthma/Lung Disease			Borderline Personality
		STD (type): _____			Thyroid Disease			Hormonal Issues
		Mumps			Lupus			Men: Prostate Issues
		Osteoporosis/Osteopenia			Headaches/Migraines			Men: Testicular Cancer
		Arthritis: _____			Skin Disease			Other:
		Diabetes			Urinary Problems			Other:

WOMEN ONLY:

		Abnormal Vaginal Bleeding			Abnormal Pap Smear			Uterine Fibroids
		Fibrocystic Breasts			Vaginal problems			Other:

SURGERIES (and approx year)

Year	Procedure	Year	Procedure	Year	Procedure
	REMOVED UTERUS		REMOVED OVARIES		FACE LIFT
	MASTECTOMY R L		CERVIX SURGERY		LIPOSUCTION
	GALL BLADDER		APPENDIX		TUMMY TUCK
	TONSILS OR ADENOIDS		SPLEEN REMOVED		BREAST AUG/LIFT
	OTHER:				

Reason for removal of any female organs: _____

FAMILY HISTORY OF ANY OF ABOVE: _____

Cigarettes Smoked per day _____ Weekly Alcohol Amount _____ Immunizations: _____

Amount of weekly exercise: _____

Describe your diet: _____

Anything else we should know about you? _____

Any details you want to add about above? _____

I hereby grant permission to **Robert L. True, M.D.** to employ such established treatments and therapy as may be deemed professionally necessary or advisable in the diagnosis and treatment of my condition or ailments. This authorization shall remain in full force and effect for this and future visits unless the consent is cancelled by my personal written notice filed with the above physician. I understand that the practice of medicine is not an exact science and there are no guarantees as to the diagnosis or result of examination or treatment in this office.

Patient's Signature (or guardian) _____ Date _____

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