



Mitchell Huebner MD

INTERNAL MEDICINE
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Name: _____ Date of Birth: _____ Date: _____

We are happy you chose us to assist you with your health care needs. Please help us by updating your medical history.

Do you have any specific concerns today? _____

Any serious injuries, illnesses, surgeries, or hospitalizations since your last visit? _____

Medications changes since your last visit? _____ Prescriptions you need refilled? _____

Current Pharmacy / Address: _____ Phone: _____

Allergies (Medications, food, etc.): Please indicate type of reaction _____

Smoke or Vape? Y / N Amount? _____ Drink alcohol? Y / N Amount? _____ Exercise? Y / N Amount? _____

Please check symptoms that you are CURRENTLY experiencing:

Constitutional:	YES	NO	Head Neck Throat:	YES	NO	Gastrointestinal:	YES	NO
Appetite Change			Earache			Swallowing Problems		
Chills			Decreased Hearing			Abdominal Pain		
Fatigue			Ringing in the Ears			Bloating		
Fever			Congestion			Vomiting Blood		
Night Sweats			Nosebleeds			Heartburn		
Weight Change			Postnasal Drip			Nausea		
Endocrinology:	YES	NO	Sinus Pain			Vomiting		
Heat or Cold Intolerance			Sneezing			Change in Bowel Habits		
Excessive Sweating			Snoring			Constipation		
Increased Thirst			Dental Problems			Diarrhea		
Increased Urination			Mouth Sores			Bleeding From Rectum		
Allergy / Immunology:	YES	NO	Sore Throat			Rectal Pain		
Environmental Allergies			Hoarseness			Jaundice		
Decreased Immunity			Neck Mass			Chest/Breast:	YES	NO
Hives			Eyes:	YES	NO	Lump/Mass		
Hematology:	YES	NO	Discharge			Discharge		
Enlarged Lymph Nodes			Itching			Genitourinary-Women:	YES	NO
Easy Bruising/Bleeding			Redness			Burning with Urination		
History of Transfusion			Visual Change/Blurring			Flank Pain		
Psychiatric/Behavioral:	YES	NO	Pain with Light			Urinary Frequency		
Agitation			Respiratory:	YES	NO	Blood in Urine		
Anxiety/Nervousness			Cough			Incontinence		
Behavioral Problems			Shortness of Breath			Urination at Night		
Confusion			Coughing Up Blood			Decreased Urine Output		
Depressed Mood			Chest Tightness			Urinary Urgency		
High Stress			Wheezing			Painful Intercourse		
Self Injury			Cardiovascular:	YES	NO	Genital Lesions		
Memory Loss			Chest Pain			Pelvic Pain		
Insomnia			Out of Breath-Little Exertion			Vaginal Discharge		
Sleeping Too Much			Palpitations			Vaginal Dryness		
Suicidal Thoughts/Plans			Burning in Calf Walking			Menstrual Problems		
Trouble Concentrating			Swelling in Legs			Non-menstrual Bleeding		
Neurological:	YES	NO	Skin:	YES	NO	Genitourinary-Men:	YES	NO
Balance Problems			Hair Loss			Burning with Urination		
Dizziness			Nail Changes			Flank Pain		
Speech Difficulties			Rash			Urinary Frequency		
Headaches			New/Worrisome Lesions			Blood in Urine		
Lightheaded			Non-healing Wound			Incontinence		
Numbness			Musculoskeletal:	YES	NO	Urination at Night		
Weakness			Joint Pain			Urinary Urgency		
Seizures			Joint Swelling			Erectile Dysfunction		
Loss of Consciousness			Joint Stiffness			Genital Lesions		
Tremor			Muscle Pain			Penile Discharge		
			Back/Neck Pain			Scrotal Swelling		
			Muscle Weakness			Testicular Pain		