Mitchell Huebner MD

INTERNAL MEDICINE
5477 Glen Lakes Drive, Suite 135
Dallas, TX 75231
(214) 361-2277

Name: ______________________________ **Date of Birth:** ______________ **Date:** _____________

Welcome to our practice! We are happy you chose us to assist you with your health care needs. Please help us by completing both sides of this form.

Who referred you? ___________________________

Past Medical History: Have you ever had the following? (Circle Yes or No. Leave blank if unsure)

Tuberculosis	Yes / No	Allergies/Hayfever	Yes / No	**Any other issue:** (please list)	
Pneumonia	Yes / No	Hives or Eczema	Yes / No	__________________	
Asthma	Yes / No	Anemia	Yes / No		
Emphysema	Yes / No	Bleeding tendency	Yes / No	**When was your last:**	
Arrhythmia	Yes / No	Blood transfusion	Yes / No	Pap Smear	________
Rheumatic fever	Yes / No	AIDS/HIV	Yes / No	Mammogram	________
Heart valve issues	Yes / No	Sexually Trans Infection	Yes / No	Breast exam	________
Heart disease	Yes / No	Bladder infection	Yes / No	Prostate exam	________
Heart attack	Yes / No	Kidney disease	Yes / No	PSA test	________
High blood pressure	Yes / No	Kidney stones	Yes / No	Colonoscopy	________
High cholesterol	Yes / No	Ulcer	Yes / No	Tetanus shot	________
Thyroid disease	Yes / No	Hepatitis	Yes / No	Shingles shot	________
Diabetes	Yes / No	Liver disease	Yes / No	Pneumonia shot	________
Cancer	Yes / No	Gallbladder problem	Yes / No	Hepatitis A & B shots	________
Alcohol/Drug issues	Yes / No	Crohns/colitis	Yes / No	Flu shot	________
Emotional problems	Yes / No	Hemorrhoids	Yes / No	Other vaccinations	________
Glaucoma	Yes / No	Hernia	Yes / No	Bone density	________
Migraines	Yes / No	Osteoporosis	Yes / No	EKG	________
Seizures	Yes / No	Back/Neck problems	Yes / No	Cardiac stress test	________
Stroke	Yes / No	Arthritis	Yes / No		

Serious illness, injury, surgeries or hospitalizations: please list with date of occurrence

____

____

Allergies (medications, food): please indicate type of reaction

____

Family History: Please include any family members with a history of diabetes, heart disease, high blood pressure, cancer, emphysema, kidney disease, asthma, bleeding tendencies, anemia, epilepsy, glaucoma, gout, arthritis, ulcer, gallbladder disease, stroke, emotional/psychiatric issues.

	Age	Health Problems	Age at Death	Cause
Father				
Paternal Grandfather				
Paternal Grandmother				
Mother				
Maternal Grandfather				
Maternal Grandmother				
Brothers				
(how many? ____)				
Sisters				
(how many? ____)				
Sons				
(how many? ____)				
Daughters				
(How many? ____)				

Social History:

Marital Status: ____________ Highest level of education: ____________ Occupation: ____________

Frequency/amount of alcohol use: ________________ Frequency/amount of tobacco/Vape use: ________________

Frequency/amount of drug use: ________________ Frequency/amount of caffeine use: ________________

Frequency/amount of exercise: ________________

Current Medications: Include non-prescription medication, vitamins, and/or supplements **(*Attach list if available)**

Medication:	Dose:	Frequency:	Need Refill?
______________	________	____________	Yes / No
______________	________	____________	Yes / No
______________	________	____________	Yes / No
______________	________	____________	Yes / No
______________	________	____________	Yes / No

Current Pharmacy / Address: ________________________________ **Phone:** ______________

Other Doctors you see:

____

Do you have any specific concerns today?

____

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/Stiffness			Erectile Dysfunction		
Loss of Consciousness			Muscle Weakness			Genital Lesions		
Tremor			Muscle Pain			Penile Discharge		
			Back Pain			Scrotal Swelling		
			Neck Pain			Testicular Pain		