## Darien W. Bradford, MD

515 W. Mayfield Rd. Suite 404 Arlington, TX 76014 Phone (817) 465-5311 Fax (817) 465-8569

Please fill in each blank as accurately as possible so that your health can be fully evaluated.

| Patient Name:   |                                      | [               | OOB:   |                                  |                 |                  |               |
|---|--------------------------------------|-----------------|--|----------------------------------|-----------------|------------------|---------------|
| ALLERGIES:  |                                      |                 |  |                                  |                 |                  |               |
| Medication Name/Dosage                                | Frequency                            | Date<br>Started |  | Social His                       | tory:           |                  |               |
|   |                                      | June            |  | Have you e                       | ver smoked (    | or chewed, if :  | so what kind? |
|   |                                      |                 |  | Quantity?                        | Yea             | ar Started?      |               |
|   |                                      |                 |  |                                  |                 |                  |               |
|   |                                      |                 |  | Ever tried t                     | o quit?         | Date St          | opped?        |
|   |                                      |                 | 192  | Do you drir                      | nk alcohol? _   |                  |               |
|   |                                      |                 |  | How many                         | drinks do yo    | u normally ha    | ve?           |
|   |                                      |                 |  | How often do you normally drink? |                 |                  |               |
|   |                                      |                 |  | If you previ                     | ously drank a   | alcohol, date s  | stopped?      |
|   |                                      |                 |  |                                  |                 |                  |               |
|   |                                      |                 |  | Have you e                       | ver used illici | t drugs, if so v | what kind?    |
| lease list any personal n<br>ospitalizations and dise |                                      |                 |  | How long d                       | id you use? _   | Date S           | Stopped?      |
|   |                                      |                 |  | Do you hav                       | e a living will | ?                |               |
|   |                                      |                 |  |                                  |                 |                  |               |
| Family Histo  | ory: (circle all th                  | at apply)       |  |                                  |                 |                  | Deceased Age  |
| Father  | Elevated BP                          | Cancer Type:    | Diabetes   | Heart Disease                    | Stroke Other    | :                |               |
| Mother  |                                      | Cancer Type:    |  |                                  |                 |                  |               |
| Sisters   |                                      | Cancer Type:    |  | Heart Disease                    |                 |                  |               |
| Brothers  | Charles and the second second second | Cancer Type:    |  | Heart Disease                    |                 |                  |               |
| Grandparents  |                                      | Cancer Type:    |  | Heart Disease                    |                 |                  | ( <del></del> |
| Uncles  | Elevated BP                          | Cancer Type:    | The state of the s | Heart Disease                    |                 |                  |               |
| Aunts   | Elevated BP                          | Cancer Type:    |  | Heart Disease                    |                 |                  | -             |
| Other:  | Elevated BP                          | Cancer Type:    | Diabetes   | Heart Disease                    | Stroke Otne     | E                |               |
|   |                                      |                 |  |                                  |                 |                  |               |
|   |                                      |                 |  |                                  |                 |                  |               |
|   |                                      |                 |  |                                  | <u> </u>        | V 1 101 1        | Detr          |
| Patie   | ent Signature                        |                 |  | Date                             | Physicia        | n's Initials     | Date          |

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## PAST OR PRESENT CONDITIONS/SYPTOMS: PLEASE CHECK ALL THAT APPLY

| CONSTITUTIONAL                           | Excessive Exposure to Noise  | Nocturia                         |
|--|------------------------------|----------------------------------|
| Change in appetite- Increase or Decrease | Olfactory Disturbance        | Nocturnal Shortness of Breath    |
| Chills/Rigor                             | Nose bleeding                | Orthopnea                        |
| Decreased activity                       | Facial pain                  | Irregular Heartbeat/Palpitations |
| Fatigue                                  | Nasal congestion             | Syncope                          |
| Insomnia                                 | Nasal Obstruction            | Other:                           |
| Irritability                             | Runny Nose                   | VASCULAR                         |
| Lethargy                                 | Sinusitis                    | Claudication                     |
| Malaise                                  | Sneezing                     | Cool Extremity                   |
| Night Sweats                             | Change in taste              | Cyanosis                         |
| Pallor                                   | Voice Change                 | Erythema                         |
| Weakness                                 | Cold sores                   | Pain (Vascular)                  |
| Weight Gain                              | Difficulty swallowing        | Raynaud's                        |
| Weight Loss                              | Hoarseness                   | Thrombophlebitis                 |
| Other:                                   | Lump in throat               | Ulcer                            |
| HEENT                                    | Mouth Sores                  | Varicose Veins                   |
| Headache                                 | Painful Swallowing           | Paresthesias                     |
| Burning eyes                             | Post Nasal Drainage          | GASTROINTESTINAL                 |
| Double Vision                            | Sore Tongue                  | Abdominal Mass                   |
| Eye Discharge                            | Pharyngitis                  | Abdominal Pain                   |
| Dry eyes                                 | Snoring                      | Bloating                         |
| Foreign Body Sensation                   | Tooth Pain                   | Blood in Stool                   |
| Itchy Eyes                               | Other:                       | Change in Bowel Habits           |
| Nystagmus                                | RESPIRATORY                  | Constipation                     |
| Eye Pain                                 | Accelerated Respirations     | Diarrhea                         |
| Photophobia                              | Cough                        | Fecal Incontinence               |
| Eye Redness                              | Cyanosis                     | Flatulence                       |
| Scotoma                                  | Shortness of Breath          | Heartburn                        |
| Floaters                                 | Hemoptysis                   | Hematemesis                      |
| Fearing                                  | Painful Respirations         | Hemorrhoids                      |
| Wears Glasses                            | Pleuratic Pain               | Jaundice                         |
| Wears Contacts                           | Snoring                      | Melena                           |
| Cataracts                                | Sputum                       | Nausea                           |
| ar Discharge                             | Stridor                      | Rectal Bleeding                  |
| xcessive Cerumen                         | Wheezing                     | Reflux (GERD)                    |
| ar Fullness                              | Frequent URI                 | Vomiting                         |
| Hearing Loss (Right or Left)             | Known TB Exposure            | Other:                           |
| ar Infections                            | Other:                       | GENITOURINARY                    |
| Otalgia                                  | CARDIOVASCULAR               | Back Pain                        |
| Ringing in ears                          | Chest Pain (Cardiac Related) | Change in Urine Color            |
| /ertigo                                  | Edema                        | Cloudy Urine                     |

Continue on back....

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| Decreased Stream              | Non-Oral Contraception        | Incoordination            |
|-------------------------------|-------------------------------|---------------------------|
| Decreased Urine Output        | Oral Contraception            | Light-headedness          |
| Painful Urination             | Ovarian Cysts                 | Loss of Consciousness     |
| Flank Pain                    | Sexual Dysfunction            | Memory Impairment         |
| Foul Urine Odor               | Vaginal Itch                  | Fainting/Near Syncope     |
| Frequent Urination            | Vaginal Discharge             | Paresthesias              |
| Groin Mass                    | Other:                        | Seizures                  |
| Blood in urine                | METOBOLIC/ENDOCRINE           | Speech Changes            |
| Hesitancy                     | Abnormal Habitus              | Visual Changes            |
| Night Urination               | Abnormal Hair Distribution    | Appropriate Interaction   |
| Passage Stone/Gravel          | Abnormal Sleep Pattern        | Consolability             |
| Excessive Urine               | Change in Sleep/Awake Pattern | Difficulty Contrating     |
| Suprapubic Pain               | Chronically Overweight        | Emotional                 |
| Urgency                       | Chronically Underweight       | Depression                |
| Urinary Incontinence          | Coarse Hair                   | Other:                    |
| Other:                        | Cold Intolerence              | DERMATOLOGIC              |
| REPRODUCTIVE-MALE             | Excessive Diaphoresis         | Acne                      |
| Circumcised                   | Goiter                        | Contact Allergy           |
| Decreased Libido              | Gynecomastia                  | Excessive Sweating        |
| Erectile Pain                 | Hair Loss                     | Frequent Skin Infections  |
| Blood in Semen                | Heat intolerance              | Nail Changes              |
| Herpes Genitalis              | Hyperpigmentation             | Photosensitivity          |
| Infertility                   | Hypoglycemia                  | Pigment Changes           |
| Penile Discharge              | Increase in Size              | Rash                      |
| Scrotum/Testicular Pain       | Infertility                   | Change in Mole            |
| Scrotum/Testicular Mass       | Insulin Reactions             | Other:                    |
| Sexual Dysfunction            | Jaundice                      | MUSCULOSKELETON           |
| History of hydrocele          | Numbness                      | Back Pain                 |
| VDRL positive                 | Excessive Thirst              | Bone/Joint Symptoms       |
| Other:                        | Eating too much               | Muscle Pain/Weakness      |
| REPRODUCTIVE-FEMALE           | Tremors                       | Neck Stiffness            |
| Breast Lumps                  | Other:                        | Other:                    |
| Breast Discharge              | NEUROLOGIC/PSYCH              | HEMATOLOGIC/IMMUNOLOGICAL |
| Breast Pain                   | Aphasia                       | Asthma                    |
| Painful Intercourse           | Dizziness                     | Easy Bleeding             |
| Fibroids                      | Dysarthria                    | Lymphadenopathy           |
| History of abnormal PAP Smear | Focal Weakness                | Easy Bruising             |
| History of Infertility        | Gair Disturbance              | Thromboembolic Events     |
| Menopausal                    | Incontinence                  | Other:                    |

| Patient Signature: | Date:            | Physician's Initials: |
|--------------------|------------------|-----------------------|
|                    | Continue on back |                       |
|                    |                  | *                     |