HILL FAMILY MEDICINE & SKIN CARE

Dr. Svetlana Megley Hill, MD Dr. Matthew S. Hill, DO
Board Certified Family Medicine Doctors

11420 Bee Cave Road, Suite A-150, Austin, TX 78738 Phone: 512-428-5764 Fax: 512-428-6021
www.hillfamilyclinic.com

Date:

1. Patient Name: _____Title: Mr. Mrs. Ms. Dr. _____
2. Date of Birth: _____

2. List all CURRENT MEDICATIONS (Prescription, over-the-counter medications and supplements):
   1.
   2.
   3.
3. List any ALLERGIES TO MEDICATIONS:
   _____

4. PAST HISTORY: Please circle which of the following apply (if any):

Diabetes	Bleeding problems	Please list any other diseases:
High blood pressure	Seasonal Allergies	1.
Thyroid problems	Stomach or intestinal problems	
Heart disease	Kidney problems	2.
Cholesterol problems	Neurological problems	
Asthma	Cancer	3.

5. FAMILY HISTORY: Please circle whether either of your parents, brothers of sisters have or have had any of the following illnesses:

Heart disease or stent	Cancer	Diabetes
High blood pressure	Migraines	Skin problems
		Other _____

6. SOCIAL HISTORY: What is your occupation?_____
Do you smoke? Yes or No Do you drink? Yes or No Do you use recreational drugs? Yes or No

7. SURGERIES: Circle any previous operations below:

Heart bypass	Appendix	Back/Neck
Gall bladder	Hernia	Other_____
Hysterectomy		

8. SURGERIES: Circle any previous operations below:

Heart bypass	Appendix	Back/Neck
Gall bladder	Hernia	Other_____
Hysterectomy		

9. Are you in today for a cosmetic consultation/procedure? Circle Yes or No. If Yes, please indicate what consultation/procedure and then stop here. No need to complete 2nd page. _____

1 Patient Signature _____ Date:_____

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10. Are you in today for establishment of care? Circle Yes or No

9. Please circle Yes or No for symptoms related to your visit:

GENERAL	fever	LUNGS	cough	NERVES	Headache
	Fatigue		wheezing		passing out/seizure
	Weight loss/gain		coughing blood		weakness in arms or legs
	Chills		problems taking a deep breath		numbness in arms or legs
	Sweating at night		Pain with deep breath		memory loss
					Blurry vision
					Uncontrollable bowel /bladder

EYES	eye pain/pressure	HEART	chest pain	MUSCLE/	joint swelling
EARS	vision changes		heart racing	SKIN	muscle aches
NOSE	watery or itchy eyes		ankle-swelling		rash
THROAT	hearing loss		problem breathing		hives
	Head spinning		laying down		itching
	Earache				
	Sinus pressure or	ABDOMEN	changes in appetite		blood in urine
	Pain		abdominal pain		painful urination
	Ear noise		diarrhea/constipation		urinating all night
	Sneezing		heartburn		vaginal discharge/
	Throat pain		nausea/vomiting		itching

GLANDULAR	Excessive thirst	BLEEDING	bleeding gums
	Excessive urination		easy bruising
	Excessive hunger		
	Swollen glands		

 Patient Signature _____ Date:_____