

DeWitz Family Medicine PLLC

Heartfelt care for the whole family

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Please indicate the approximate date you performed each the following screening tests or vaccinations

Physical exam	Colonoscopy	Mammogram	Flu vaccine
Testicular exam	Stool card for colon cancer	Bone Density test	Pneumonia vaccine
Eye exam	Sigmoidoscopy	Pap smear	Tetanus vaccine
Rectal Prostate exam	Cholesterol labs		MMR vaccine
Dental exam	Comprehensive blood work		Shingles vaccine
Stress test	PAD screening		
TB test	Carotid Artery disease screening		

Obstetrical History

Number of pregnancies	Number of births	Number of abortions	Number of miscarriages
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Please check all the following conditions you have had now or in the past.

Abdominal pain	Gout	Suicide attempts
Allergies	Headache (Chronic)	Thyroid disease (specify)
Anemia	Hearing loss	TIA
Anxiety	Heart attack/CAD	Ulcers
Arthritis/joint pain	Heart Failure	Urinary Incontinence
Bladder infections	Heart Murmur	
Blood in stool	Heartbeat irregular	
Breathing problems	Heartburn	
Broken bones (specify)	Hemorrhoids	
Cancer (specify)	Hepatitis	
Cataracts	High Blood Pressure	
Chronic skin conditions	Hives	
Colon polyps	Kidney stones	
Constipation	Mental illness	
Dentures	Memory loss/dementia	
Dental problems (specify)	Moles	
Depression	Panic attacks	
Diabetes	Physical abuse	
Diarrhea	Pneumonia	
Ear problems (specify)	Prostate problems	
Emphysema/COPD	Seizures	
Frequent Bronchitis	Sexual abuse	
Frequent sinus infections	Sexually transmitted disease	
Glaucoma	Stroke	

Is there any other information that will help us care for you better?

Patient or patient's representative signature _____

Date _____