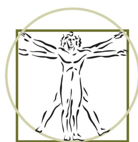

Sage Medicine

4114 Pond Hill Rd, #202
Shavano Park, Texas 78231

Carmen Cawley, M.D.

Patient Name: ______________________ Today's Date: ______________

SS/HIC/Patient ID # ____________ Age: ____________ Birthdate: ______________

What is your reason for visit? ______________________________

Symptoms

Check ☑ symptoms that you have

General
- ☐ Weight loss
- ☐ Weight gain
- ☐ Fever
- ☐ Chills
- ☐ Sweats
- ☐ Fatigue

Eye, Ear, Nose, Throat
- ☐ Vision problem or change
- ☐ Hearing problem or change

Pain or drainage from:
- ☐ Eyes
- ☐ Ears
- ☐ Nose/sinus
- ☐ Mouth/throat

Neck
- ☐ Lumps
- ☐ Goiter
- ☐ Pain
- ☐ Stiffness

Breast
- ☐ Lumps
- ☐ Pain
- ☐ Nipple discharge
- ☐ Swelling/enlargement

Pulmonary
- ☐ Cough
- ☐ Productive sputum
- ☐ Wheeze
- ☐ Shortness of breath
- ☐ Sleep on more than 1 pillow

Cardiac
- ☐ Chest pain at rest
- ☐ Chest pain on exertion
- ☐ Murmur
- ☐ Palpitations

Vascular
- ☐ Pain calves when walking
- ☐ Leg cramps
- ☐ Varicose veins
- ☐ Clots
- ☐ Swelling of ankles

Gastrointestinal
- ☐ Heartburn/Indigestion/gas
- ☐ Pain or problem swallowing
- ☐ Stomach pain
- ☐ Abdominal pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Bloating/distension
- ☐ Mass
- ☐ Change in bowel habits
- ☐ Vomiting blood
- ☐ Rectal Bleeding
- ☐ Melena (tarry black stools)
- ☐ Hemorrhoids

Urinary
- ☐ Frequent urination
- ☐ Urgency
- ☐ Pain with urination
- ☐ Blood in urine
- ☐ Hesitancy with urination
- ☐ Incontinence
- ☐ Stones
- ☐ Recurrent UTI's

Endocrine
- ☐ Thyroid problem
- ☐ High glucoses
- ☐ Low glucoses
- ☐ Increased thirst
- ☐ Increased sweats
- ☐ Heat intolerance
- ☐ Cold intolerance

Musculoskeletal
- ☐ Muscle pain
- ☐ Joint pain
- ☐ Stiffness
- ☐ Gout
- ☐ Neck pain
- ☐ Back pain
- ☐ Change in mobility

Neuropsychiatric
- ☐ Dizziness
- ☐ Fainting
- ☐ Seizures
- ☐ Weakness
- ☐ Paralysis
- ☐ Numbness/tingling
- ☐ Tremors
- ☐ Headaches
- ☐ Depressed mood
- ☐ Sleep increased or decreased
- ☐ Interest activities decreased
- ☐ Guilt/worthless feelings
- ☐ Energy low/fatigue
- ☐ Concentration difficulty
- ☐ Appetite increased or decreased
- ☐ Increased anxiety or agitation
- ☐ Suicidal thoughts

Heme
- ☐ Anemia
- ☐ Increased Bleeding
- ☐ Increased Bruising
- ☐ Transfusions
- ☐ Familial d/o (clotting/bleeding)

Skin
- ☐ Rash
- ☐ Lumps
- ☐ Sores or ulcers
- ☐ Dryness
- ☐ Color changes
- ☐ Hair changes
- ☐ Nail changes
- ☐ Hives
- ☐ Itching

Women Only
- ☐ Abnormal pap smear
- ☐ Bleeding between periods
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Painful intercourse
- ☐ Vaginal discharge

Date of last menstrual period: ______________ Date of last mammogram: ______________

Date of last pap smear: ______________ Method of contraception ______________

Number of pregnancies: ______________ Number of live births: ______________

Number of miscarriages: ______________ Number of abortions: ______________

Number of living children: ______________ Are you pregnant? ______________

Men Only
- ☐ Sexual difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis

Medical Conditions

Check ☑ conditions that you have or have had (please elaborate)

Condition	
☐ Alcohol dependence	☐ High blood pressure
☐ Allergies/hay fever/ Sinusitis	☐ High cholesterol
☐ Anemia (Iron, B12...)	☐ HIV/AIDS
☐ Anorexia/Bulimia	☐ Hypothyroid
☐ Angina/Chest pain/Heart attack	☐ Hyperthyroid
☐ Arthritis	☐ Incontinence (Urge, Stress...)
☐ Asthma / Emphysema	☐ Irregular or fast heart beat
☐ Autoimmune disease (Lupus, Sjogren's, Scleroderma…)	☐ Irritable Bowel Syndrome
☐ Bleeding / Clotting disorder	☐ Mitral Valve Prolapse
☐ Cancer	☐ Memory problem/Dementia
☐ Celiac Disease	☐ Mononucleosis
☐ Chronic bronchitis/Emphysema	☐ Neuromuscular disorder
☐ Chronic kidney disease	☐ Obesity
☐ Chronic liver disease	☐ Pacemaker
☐ Colon disorder(Ulcerative colitis, Crohn's,Diverticulitosis,IBS…)	☐ Polio
☐ Congestive Heart Failure or enlarged heart	☐ Prostrate problem
☐ Chicken Pox/Shingles	☐ Psychiatric (Anxiety, Bipolar, Depression, Anxiety, ADD…)
☐ Diabetes I or II	☐ Rheumatic Fever
☐ Drug dependency	☐ Seizures/Epilepsy
☐ Fibromyalgia	☐ Sleep Apnea
☐ Genetic Disorder	☐ Stomach ulcers / Duodena Ulcers
☐ Goiter/thyroid nodules	☐ Stroke or mini-stroke
☐ Gout	☐ Suicide Attempt
☐ Headaches (Migrane, Tension..)	☐ Sexually Transmitted Disease
☐ Head injury	☐ Sickle Cell anemia
☐ Heart - Abnormal Beat (slow, fast, irregular...)	☐ Skin Disorders (Acne, Psoriasis...)
☐ Heartburn	☐ Tuberculosis
☐ Hemorrhoids/rectal problems	☐ Urinary Tract Infections (only if recurrent)
☐ Hepatitis (A,B,C, Non Infectious)	☐ Valve disease / heart murmur
☐ Hernia	☐ Vascular disease (carotid, heart, renal, peripheral arteries)
☐ Other	☐ Vein problems / cellulitis / leg ulcers
	☐ Other

Medications
List medications, supplements, and herbs you are currently taking

Medication	*Dosage*	*Frequency*	*Medication*	*Dosage*	*Frequency*

Allergies to medications and foods
(describe reaction like rash, anaphylactic shock…)

Marital Status:
☐ Married ☐ Divorced ☐ Single ☐ Separated ☐ Widowed ☐ Partnered

Are you sexually active? ☐ Yes ☐ No

Have you ever been physically or verbally abused by a partner? ☐ Yes ☐ No

Health Habits
Check ☑ substances you use **and describe how much you use**

☐ Tobacco

☐ Alcohol

☐ Drugs

☐ Caffeine

Occupational
Check ☑ if your work exposes you to the following:

☐ Stress ☐ Hazardous Substances

☐ Heavy Lifting ☐ Other

Occupation:

Family History
- list Arthritis, Gout, Asthma, Allergies, Cancer, Chemical Dependency, Diabetes, Heart Disease, Strokes, High Blood Pressure, High Cholesterol, Kidney Disease, Liver Disease, Tuberculosis, Mental Disorder

Relation	Age	Cause of Death	Age at Death	Diseases?
Father				
Mother				
Brothers				
Sisters				
M Grandfather				
M. Grandmother				
P. Grandfather				
P. Grandmother				

Surgeries		
Date	Hospital	Surgery or Illness
Serious Illnesses/Hospitalizations		

Vaccines	Date of last vaccine
Pneumococcal (1 or 2)	
Tetanus—Td every 10 yrs	
Tetanus—TdaP (1)	
Hepatitis B series (3)	
Hepatitis A series (2)	
MMR (1 before & after 50)	
HPV (gardasil or cervarix—3)	
Meningococcal (1)	
Zostavax (1 over 50)	
Varicella (2 if no chickenpox)	
Colonocopy (screening) Result	
Other	

**** Have you ever had a blood transfusion?** ☐ **Yes** ☐ **No** If yes, give approximate date: ____________

Pregnancy Complications	
Year	Complication

DO YOU HAVE ADVANCED DIRECTIVES? ☐ Yes ☐ No

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his / her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature: ____________ *Date:* ____________

Reviewed By: ____________ Date: ____________