



Mail or Fax to:
5656 Bee Caves Rd., Suite D202
Austin, TX 78746
(512) 327-7700 Fax (512) 327-7701

New Patient Visit

Name		Date of Visit	
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Why are you here to see Dr. Silvertooth?	
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Medication Allergies:		Preferred Pharmacy:	
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Medical History: Please check all that apply.

- | | | |
|---|--|---|
| <input type="checkbox"/> Acid reflux | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Atrial fibrillation | <input type="checkbox"/> Head injury | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Alzheimer's disease | <input type="checkbox"/> Headache/migraine | <input type="checkbox"/> Prostate/enlarged |
| <input type="checkbox"/> Allergy/hay fever | <input type="checkbox"/> Headache/tension | <input type="checkbox"/> Seizure/epilepsy |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Sleep apnea |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Sleep disorder |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Cancer: What type? | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Liver/hepatitis | <input type="checkbox"/> <u>Other:</u> |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Low back pain | |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Neck pain | |

Prior Surgeries/Procedures

Date

Date

- | | |
|---|---|
| <input type="checkbox"/> Low back | <input type="checkbox"/> Cataract removal |
| <input type="checkbox"/> Cervical | <input type="checkbox"/> Prostate |
| <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Breast implant |
| <input type="checkbox"/> Coronary stent placement | <input type="checkbox"/> Breast biopsy |
| <input type="checkbox"/> Coronary artery bypass | <input type="checkbox"/> Pacemaker implant |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> VNS implant |
| | <input type="checkbox"/> <u>Other:</u> |

Past Psychiatric History: check any prior diagnoses or symptoms

- | | | |
|---|---|---|
| <input type="checkbox"/> Anorexia Nervosa | <input type="checkbox"/> Bulimia Nervosa | <input type="checkbox"/> Schizophrenia/ |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Delirium | Schizoaffective Disorder |
| <input type="checkbox"/> Asperger's Disorder | <input type="checkbox"/> Dementia | <input type="checkbox"/> Somatization |
| <input type="checkbox"/> Attention Deficit/
Hyperactivity Disorder | <input type="checkbox"/> Depression | <input type="checkbox"/> Tourette's Disorder |
| <input type="checkbox"/> Autistic Disorder | <input type="checkbox"/> Dissociative Disorder | <input type="checkbox"/> <u>Other:</u> |
| <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Panic Attacks | |
| <input type="checkbox"/> Borderline Personality
Disorder | <input type="checkbox"/> Phobias/Social Phobia | |
| | <input type="checkbox"/> Posttraumatic Stress
Disorder | |

Past Psychiatric Medications and Side Effects (please list):	
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Previous Psychiatric Hospitalizations (places, dates):	
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Social History

- | | | | | |
|------------------------|----------------------------------|---|--|-----------------------------------|
| Alcohol Use | <input type="checkbox"/> None | <input type="checkbox"/> Rare | <input type="checkbox"/> Occasional | <input type="checkbox"/> Frequent |
| Marital History | <input type="checkbox"/> Married | <input type="checkbox"/> Single | <input type="checkbox"/> Widowed | <input type="checkbox"/> Divorced |
| Tobacco Use | <input type="checkbox"/> None | <input type="checkbox"/> Current Smoker | <input type="checkbox"/> Former Smoker | |
| Drug Use | <input type="checkbox"/> None | <input type="checkbox"/> Current drug use | <input type="checkbox"/> Former drug use | |

Occupation:	
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Please list medical, psychiatric, or alcohol/drug problems that have occurred in your family:

Mother

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Father

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Maternal grandmother

--

Maternal grandfather

--

Paternal grandmother

--

Paternal grandfather

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Brothers/sisters

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Thank you for completing! Please fax or mail to address on first page prior to visit.