UT★Physicians

Allergies: ☐ NKA ☐ Yes
Drug: _____
Other: _____
Wt: _____ kg. Ht: _____cm.

COMPREHENSIVE SICKLE CELL CENTER

Reason for Visit Today:			**Surgical History**	**Yes**	**No**
Name of Primary Care Provider:			Heart Bypass/Date:		
Name of Hematologist:			Breast Surgery/Date:		
Pain	**Yes**	**No**	Splenectomy/Date:		
Are you in pain?			Appendectomy/Date:		
Vaccination/Immunization	**Yes**	**No**	Gallbladder Removal/Date:		
Influenza (Flu Vaccine) After Sept 1st/Date:			Hysterectomy only/Date:		
Pneumovax (Pneumococcal)/Date:			Hysterectomy and ovaries removed/Date:		
Hep B Series/Completed Date:			Hernia Repair/Date:		
Meningococcal/Date:			Orthopedic/Date:		
Hemophillus Influenza type b (Hib)/Date:			Other:		
Other vaccine:			**Vascular Access/Location**	**Yes**	**No**
Other vaccine:			Implanted Port: ☐ Right ☐ Left		
Social History	**Yes**	**No**	Perm-a-Cath: ☐ Right ☐ Left		
Smoker? ☐ Current ☐ Past ____#pk/wk			PICC: ☐ Right ☐ Left		
Alcohol use? ☐ Current ☐ Past			Fistula: ☐ Right ☐ Left		
Recreational Drugs/type:			**Family History** F=Father M=Mother S=Sibling G=Grandparent		
Medical History	**Yes**	**No**	Autoimmune ☐ F ☐ M ☐ S ☐ G		
Acute Chest Syndrome/Date:			Cancer ☐ F ☐ M ☐ S ☐ G		
Anemia			Sickle Cell Trait ☐ F ☐ M ☐ S ☐ G		
Anxiety			Hemoglobin C Trait ☐ F ☐ M ☐ S ☐ G		
Arthritis/Lupus			Sickle Cell Disease ☐ F ☐ M ☐ S ☐ G		
Avascular Necrosis			Thalassemia ☐ F ☐ M ☐ S ☐ G		
Bleeding/Clotting Problems			Diabetes ☐ F ☐ M ☐ S ☐ G		
Cancer			Heart Disease ☐ F ☐ M ☐ S ☐ G		
Congested Heart Failure (CHF)			High Blood Pressure/Hypertension ☐ F ☐ M ☐ S ☐ G		
Chronic Obstructive Pulmonary Disease (COPD)			**General Symptoms/Diagnostic Tests**	**Yes**	**No**
Depression			Have you experienced any of these symptoms in the last 6 months?		
Diabetes			Fatigue		
Emphysema/Asthma			Fever/Chills		
GI Problems/Reflux/Ulcers			**ENT**	**Yes**	**No**
Heart attack/Myocardial Infarction			Hearing loss/Aids ☐ Right ☐ Left ☐ Both		
Hepatitis			Mouth sores		
High Blood Pressure/Hypertension			Difficulty Swallowing		
High Cholesterol			Changes in vision		
Kidney Disease/Kidney Stones			Last eye exam/Date: Eyes Dilated?		
Liver Disease			**Respiratory**	**Yes**	**No**
Migraines/Headaches			Shortness of breath		
Osteomyelitis			Cough/Coughing up blood in the last 2wks		
Pace Maker			Last chest x-ray/Date: Normal?		
Pneumonia			**Cardiovascular**	**Yes**	**No**
Pregnancy: #Preg ___ #Living Children___			Chest Pain		
Positive TB Test			Swelling in extremities/edema		
Priapism (prolonged erection)			Leg pain with walking		
Prostate Problems			Last ECHO/Date: Normal?		
Pulmonary Hypertension			**Gastrointestinal**	**Yes**	**No**
Seizures			Nausea/Vomiting		
Sickle Cell Disease/type:			Abdominal pain/swelling		
Stroke			Diarrhea		
Thyroid Disease			Constipation		
Other:			Black stools/blood in stool		
Other:			Last MRI of liver/Date: Normal?		

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Genitourinary/Reproductive	Yes	No
Pain upon urination		
Blood in urine		
Urinary incontinence		
Last menstrual cycle/Date:		
Birth Control/Method:		
Breast	**Yes**	**No**
☐ Pain ☐ Swelling ☐ Lump		
Skin changes on breasts		
Nipple discharge		
Last mammogram/Date: Normal?		
Neurological	**Yes**	**No**
Seizures		
Confusion		
Numbness/Tingling		
Headaches/Dizziness		
Last TCD/Date: Normal?		
Last CT of Head//Date: Normal?		
Last MRI of Brain/Date: Normal?		
Skin	**Yes**	**No**
☐ Itching ☐ Rash ☐ Eczema		
Jaundice (yellowing of skin or eyes)		
Leg Ulcer: ☐ Right ☐ Left		
Other:		
Musculoskeletal	**Yes**	**No**
Joint pain/location:		
Bone pain/location:		
Other:		

Hospitalization/Visits	Yes	No
ER visit in the last 12 months		
If yes, # of ER visits:		
Admitted to the hospital in the last 12 months		
If yes, # of admissions:		
# of admission days:		
Clinic visits in the last 12 months		
If yes, 3 of PCP visits:		
If yes, # of Heme visits:		
Therapy	**Yes**	**No**
Hydroxyurea		
Chelation Therapy for excess iron		
Chronic transfusions: ☐ Simple ☐ Exchange		
Other:		
Other:		
Other:		
Advanced Directives	**Yes**	**No**
Do you have an Advanced Directive?		
Do you wish to receive info on Advanced Directives?		

Additional Comments/Concerns

Current Medications

Medication Name	Dose	Freq.	Medication Name	Dose	Freq.

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DENTAL AND ORAL HEALTH HISTORY

Chief Dental Complaint:	Check all that apply:	Give brief description of chief dental complaint:
Cavities/lost or broken filling		
Check-up/cleaning		
Dentures/partial dentures		
Missing teeth/spaces		
How long since last dental visit:		

Dental History Information:	Yes	No	*If yes, please describe
Have you had a local anesthetic (Novacain) for dental purposes?			
Problems in the past with local anesthetic?			
Currently wear an oral or dental appliance?			
Unhappy with smile or other aspect of the way teeth look for feel?*			Description:
Dry mouth/xerostomia?*			Description:
Persistent halitosis/bad breath?			
Smoker/history of tobacco use?			
Tooth sensitivity to hot, cold, chewing, other?			
Any history of head/neck cancer with radiotherapy?			
Have had teeth whitened?			
Have received dental treatment in the past?			
Crown (cap)			
Extraction			
Filling			
Root canal			
Problem with any dental treatment?			
Other dental history information?			

TMD/Facial Pain History	Yes	No	
Facial pain or pain in your jaw joint?*			Description:
Habitually clench or grind teeth during the day or night?			
Popping, clicking, or other noises from jaw?			
Dental pain/intraoral pain?			
Loose teeth?			