Robert C. Strayhan, M.D.
1732 Galleria Oaks, Texarkana, TX 75503
(903)794-1636

Medical Screening Form

Section 1: Patient Information

Patient Name:						Date of Birth:	Age:
Status:	☐ Single	☐ Married	☐ Divorced	☐ Widowed	☐ Other	Number of Children:	
Occupation:				If retired, list previous occupation:			
Cultural/Spiritual beliefs that may affect your care? ☐ Yes ☐ No Please explain:							
Name of Primary Care Physician:				Reason for Your Visit?			

Section 2: Allergies to Medication or Food

☐ None	Medication or Food Allergy	Reaction

Section 3: Current Medications

List **ALL** current medications including over the counter medications/vitamins/herbals/supplements

Medication Name	Dosage	# Times Daily	**Medication Name**	Dosage	# Times Daily

Section 4: Social History

Regular Exercise? ☐ Yes ☐ No Type of Exercise?_____ How often?_____

Tobacco Use Cigarettes, cigars, pipes, smokeless tobacco):

☐ Never

☐ I quit When?_____ Packs per day?_____ How long?_____

☐ I still smoke Packs per day?_____ How long?_____ No. of years smoked?_____

Section 5: Surgeries

(Check all boxes that apply)

☒	**Surgery**	**Year**	☒	**Surgery**	**Year**	☒	**Surgery**	**Year**
	Appendectomy			Heart Valve			Tubes Tied	
	Aneurysm			Specify:			Vasectomy	
	Back Surgery			Lung Surgery			Hysterectomy	
	Carotid Artery			Vascular			Joint Surgery	
	C-Section			Aorta or Legs			Location?	
	Gall Bladder			Organ Transplant			Stomach Surgery	
	Ablation			Specify:			Colon Surgery	
	Heart Bypass			Stent Placement			Tonsillectomy	
	Pacemaker			Location?			Other	
	Defibrillator			Varicose Veins			Type?	

Patient Signature **Date**