Houston Family Physicians PA

Patient Information

Last Name	First Name	Middle Name	
Address	City	State	Zip Code
Home Phone	Cellular Phone (Optional)	Email Do Not Email □	

Marital Status: Single □ Married □ Divorced □ Widowed □ Separated □

Driver License #	Business owner □ Employed □ Unemployed □ Student □		
Date of Birth	Sex M □ F□	Primary Insurance	Insurance number Social Security Number
Spouse's Name	Contact Number	Occupation	
In Case of Emergency, Notify	Contact Number	Relationship	

Employment

Work Name	Work Number	Occupation	
Address	City	State	Zip Code

Responsible Party (Guarantor)

Last Name			
Address	First Name	Middle Name	
Home Phone	City	State	Zip Code

Relationship to Patient: S- self H- husband W- wife C- child P- parent O-other (please specify):

Social Security number	Date of birth	

How did you hear about us?

Was the Injury Work Related?	Date of Injury	Was the Injury Result of Accident?	Date of Accident

Consent for Treatment

I voluntarily consent and authorize Houston Family Physicians to provide me and my dependents with medical care and perform diagnostic tests.

Consent for Minor Child:

The undersigned hereby requests and authorizes Outpatient Clinical Care to perform diagnostic tests and render treatment to the patient, a minor child. This authorization extends to all other clinics, doctors. and office staff members and is intended to include radiographic examination at the doctor's discretion.

As of the date below, the undersigned states and vows to have the legal right to select and authorize health care services for the minor child named above.

If applicable, under the terms and conditions of divorce, separation or other legal authorization, the consent of a spouse, former spouse, or other parent is not required. If authority to select and authorize this care should be revoked or modified in any way, the undersigned does hereby agree to notify the Houston Family Physicians PA. as soon as is possible.

Financial Responsibility and Assignment of Benefits:

All professional services rendered are charged to the patient and are due at the time of services, unless other arrangements have been made in advance with our practice financial advisor. Necessary form will be completed to help expedite insurance carrier payments. However, I am responsible for all fees, regardless of insurance coverage.

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance, and any other health/medical plan to issue payment check(s) to Houston Family Physicians P.A. for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any.

I hereby authorize Houston Family Physicians P.A. to release any information necessary concerning my illness and treatments, to process my insurance claim, and to allow photocopy of my signature to be used to process my insurance claim for the period of life time.

The insurance information furnished here represent a fully disclosure of the insurance/third party benefit to which I am entitled. I understand that failure to disclose precertification/second opinion requirements for any and all plans to which I subscribe, may cause to incur full liability for professional charges, as a result of non-payment by any carrier,

Would you like information on a Living Will? _____Yes _____No

Signature:_____ **Date:**

Confidentiality Questionnaire

People that we may inform about your general medical condition and your diagnosis:

□ Spouse □ Children □ Parents □ Any relative □ Other (specify: _____)

IN AN EMERGENCY.

□ Spouse □ Children □ Parents □ Any relative □ Other (specify: _____)

Preferred mailing address.

□ Home □ Other-specify: Street_____ City_____ Zip Code _____

Do you want all correspondence from our office sent in a sealed envelope marked " **CONFIDENTIAL"?**

□ Yes □ No

Preferred telephone number for lab results and other communication.

□ Home □ Other-specify: ( ) _____

Can we leave confidential information on your voicemail?

Home □ Yes □ No
Office □ Yes □ No

Signature:_____ **Date:**

INITIAL MEDICAL HISTORY: PLEASE COMPLETE. ALL ANSWERS CONFIDENTIAL

Name:		Age:		Date:	
Reason for visit:					
Allergies:					

Medications: (include vitamins and over-the-counter medications)

name	dosage	frequency	name	dosage	frequency

Past Medical History (circle only those diagnosed by a doctor)

0	NONE	23	Asthma	46	Diverticulosis	69	Chronic sinus infection
1	Stroke	24	COPD/emphysema/ch bronch	47	Diverticulitis	70	Eczema
2	TIA (“mini stroke”)	25	Sleep apnea	48	Chronic constipation	71	Psoriasis
3	Seizure disorder	26	High blood pressure	49	Hemorrhoids	72	Acne
4	Tension headaches	27	Angina / coronary disease	50	Chronic kidney failure	73	Rosacea
5	Migraine headaches	28	Heart attack	51	Kidney stones	74	Osteoarthritis/Degen joints
6	Major Depression	29	Congestive heart failure (CHF)	52	Urinary incontinence	75	Rheumatoid arthritis
7	Bipolar Disorder	30	Aortic valve stenosis	53	Enlarged prostate	76	Lupus (SLE)
8	Anxiety Disorder	31	Mitral valve regurgitation	54	Erectile dysfunction	77	Osteoporosis
9	Attention Deficit Disorder /ADD	32	Mitral valve prolapse	55	Painful menstruation	78	HIV / AIDS
10	ADHD (with hyperactivity)	33	Benign heart murmur	56	Irregular menstruation	79	Tuberculosis (lung disease)
11	Mental Retardation	34	Peripheral vascular disease	57	Heavy menstruation	80	Herpes
12	Developmental Delay	35	Esophagitis	58	Polycystic ovaries	81	Gonorrhea
13	Autism	36	Acid Reflux	59	Diabetes mellitus type 1	82	Chlamydia
14	Dementia	37	Hiatal Hernia	60	Diabetes mellitus type 2	83	Syphilis
15	Parkinson’s disease	38	Gastritis	61	High cholesterol	84	Mumps
16	Essential tremor	39	Stomach ulcers	62	Hyper (high) thyroid	85	Measles
17	Tinnitus	40	Fatty liver	63	Hypo (low) thyroid	86	Rubella
18	Peripheral neuropathy	41	Hepatitis	64	Obesity	87	Polio
19	Cataract	42	Gallstones	65	Anemia	88	Tetanus
20	Glaucoma	43	Irritable bowel syndrome	66	Cancer of:_____	89	Rheumatic fever
21	Macular degeneration	44	Crohn’s disease	67	Nasal allergies	90	Chicken pox
22	Retinopathy	45	Ulcerative colitis	68	Recurrent ear infections	91	Other? _____

Past Surgical History (provide approximate dates)

□ none	□ stomach surgery for obesity	□ removal of uterus and ovaries
□ carotid artery surgery	□ removal of gallbladder	□ repair of hip fracture
□ thyroid surgery	□ removal of appendix	□ hip replacement
□ coronary artery bypass surgery	□ removal of uterus (ovaries still in)	□ other:

Family History (provide approximate age of diagnosis, if known)

	Father	Mother	Children	Siblings	Grandpt		Father	Mother	Children	Siblings	Grandpt
□ None											
Breast Cancer	A1	A2	A3	A4	A5	Mental Illness	J1	J2	J3	J4	J5
Cervix Cancer	B1	B2	B3	B4	B5	Migraines	K1	K2	K3	K4	K5
Colon Cancer	C1	C2	C3	C4	C5	Alcoholism	L1	L2	L3	L4	L5
Other Cancer	D1	D2	D3	D4	D5	Asthma	M1	M2	M3	M4	M5
Heart attack or heart vessel disease	E1	E2	E3	E4	E5	Congestive heart failure (CHF)	N1	N2	N3	N4	N5
Stroke	F1	F2	F3	F4	F5	Liver failure	O1	O2	O3	O4	O5
Diabetes	G1	G2	G3	G4	G5	Kidney failure	P1	P2	P3	P4	P5
High BP	H1	H2	H3	H4	H5	List others:	Q1	Q2	Q3	Q4	Q5
Cholesterol	I1	I2	I3	I4	I5	List others	R1	R2	R3	R4	R5

Social History and Habits

Marital status: *Single Engaged Married Widowed Divorced Separated*

Number of children:_____

Occupation: _____ Retired

Dietary Restrictions (circle): *None*
Low salt Low cholesterol / fat Low sugar
No meat No dairy Other:(specify) _____

Exercise (circle): none sedentary occasional regular

Specify exercise:_____

Sexually active? (circle): *yes no single partner multiple partners*

Always use a condom? *yes no*

Birth control (circle): *pills depo injection patc h condom IUD*

Caffeine: #_____cups/day

Smoke: #_____packs/day since age: ____

Alcohol: #_____ ounces/week

Recreational drug use (circle): *yes no*

If yes, what kind? _____

Health Maintenance

Last Cholesterol screening: _____

Last Tetanus vaccination (year): _____

Last Flu shot (month &year): _____

Last Pneumonia shot (year): _____

Hepatitis B vaccination? (circle) Yes (year?):_____ No

Tuberculosis skin test? (circle) Yes (year & result): No _____

Last eye doctor appointment (month & year): _____

Last dentist appointment (month & year): _____

(age > 65) Bone Density Scan? (year): _____

(age > 50) Last colon cancer screening (year): _____

Male : Last digital rectal prostate exam
Last PSA for prostate cancer screen _____

Female: Last Pap smear: (month & year)
Last Mammogram: (month & year) _____

New Patient History Form: Page 2

Patient Name & Age: _____
MRN: _____
Reason for Visit: _____
Date: _____

Nurse use only	Temp:
height:	Pulse:
	BP:
weight:	
	RR:
LMP:	LPS:

HOW DO YOU FEEL TODAY? (Circle all that apply)

Thank you for filling out this form completely. It will help us take better care of you.

Please **circle** all the symptoms that apply to you **TODAY or RECENTLY**. Please put the completed form in the tray on the front counter so we can get to you ASAP.

Please have **your co-pay** ready when your name is called. For your convenience, we do accept cash, check, **Mastercard and Visa**.

The doctor will address your **main concern** today. These may help the doctor to know it in more detail…

If we cannot get to all your other problems today, it is your responsibility to come back again on another day and see your doctor…

Routine lab results and x-ray reports can take 1-2 weeks before they are available.

Your doctor will call or mail you the result if it is normal. You may be asked to return to clinic if your test result is abnormal so the doctor can discuss it with you and explain its implications…

Your wellness is our business…

	Constitutional
1	none
2	significant weight gain
3	significant weight loss
4	unusual fatigue
5	weakness
6	fever
7	chills
8	night sweats
	Eyes
10	none
11	vision problems
12	blurred vision
13	double vision
14	partial visual field loss
15	pain
16	redness
17	excessive tearing
18	dryness
	Ears, Nose, Mouth, Throat
20	none
21	hearing loss
22	ringing in the ear
23	ear pain
24	mouth lesions
25	ear discharge
26	vertigo (room spinning)
27	runny nose
28	nasal congestion
29	sneezing
30	nasal itching
31	bleeding from nose
32	bleeding gums
33	sore tongue
34	sore throat
35	hoarse voice
36	neck stiffness
37	neck lump
38	neck pain
	Cardiovascular
40	none
41	chest pain
42	chest pressure
43	racing heart beats
44	shortness of breath
45	short of breath when lying down
46	waking up short of breath
47	swelling in the legs
48	cold hands or feet
49	pain in legs with minimal walk
	Respiratory
50	none
51	shortness of breath
52	wheezing
53	cough
54	productive cough
55	blood tinged sputum
56	snoring
57	stop breathing at night

	Gastrointestinal
60	none
61	pain with swallowing
62	difficulty swallowing
63	heartburn
64	excessive gas
65	feeling full after little food
66	nausea
67	vomiting
68	poor appetite
69	stomach pain
70	jaundice
71	black, tarry stool
72	constipation
73	diarrhea
74	bright red blood in stool
75	pus in stool
	Genitourinary
80	none
81	painful urination
82	urinary urgency
83	increased urinary frequency
84	bloody urine
85	excessive urination at night
86	frequent, large volume urination
87	incontinence
88	urinary hesitancy
89	not having menstrual periods
90	infrequent menstrual cycles
91	abnormally heavy menstrual flow
92	irregular menses
93	painful menstrual cycle
94	vaginal discharge
95	painful intercourse
96	blood after intercourse
97	hot flashes
98	penile discharge
99	impotence
	Skin
110	none
111	rash
112	lumps
113	changing moles
114	Itching
115	nail changes
116	breast pain
117	breast lumps
118	nipple retraction
119	nipple discharge
	Neurological
120	none
121	headache
122	fainting
123	tremor
124	paralysis
125	weakness
126	seizure
127	involuntary movements
128	abnormal skin sensation
129	falling asleep during day

	Psychiatric
130	none
131	confusion
132	nervousness
133	depressed mood
134	impaired memory
135	difficulty keeping asleep
136	increased sleep
137	obsessions
138	auditory hallucinations
139	visual hallucinations
	Endocrine
140	none
141	many urinations all day
142	unusual thirst
143	abnormal appetite increase
144	cold intolerance
145	heat intolerance
146	frequent, abnormal sweating
	Hematological/Lymphatic
150	none
151	easy bruising
152	easy bleeding
153	neck lumps or nodes
154	lumps in the arm pits
155	lumps in the groin area
	Allergic/immunologic
160	none
161	hives
162	chronic clear nasal discharge
163	wheezing
164	persistent cough
165	recurrent infections
	Musculoskeletal
170	none
171	Shoulder Swell Tender Stiff
172	Elbow Swell Tender Stiff
173	Wrist Swell Tender Stiff
174	Hand Swell Tender Stiff
175	Hip Swell Tender Stiff
176	Knee Swell Tender Stiff
177	Ankle Swell Tender Stiff
178	Foot Swell Tender Stiff
179	Upper arm Swell Tender Stiff
180	Lower arm Swell Tender Stiff
181	Thigh Swell Tender Stiff
182	Lower leg Swell Tender Stiff
183	Back pain
	Pain
	Scale (1-10, 10 is worst):
	Location:
	Quality:
	Timing: (circle)
	constant
	intermittent
	Duration: