Whitney Family Medicine

1314 N Brazos · PO BOX 2177 · WHITNEY, TX 76692
PHONE 254-694-3621 · FAX 254-694-7436

Fill out this form ENTIRELY

Patient Information

Patient Last Name:_____ First Name:_____ MI:_____

Mailing Address:_____ City:_____ State:_____ Zip:_____

Physical Address (If different than Mailing):_____

Date of Birth:_____ Home Phone #:_____ Cell Phone #:_____

Patient SS#:_____ Gender: Male Female Marital Status: Married Single Divorced Widowed

Email Address:_____

Guarantor/Parent/Responsible Party Information

Anyone under 18 is a minor and MUST be accompanied by a parent/guardian.

Responsible Parties Name:_____ DOB:_____

Mailing Address:_____ City:_____ State:_____ Zip:_____

Physical Address (If different than Mailing):_____

Phone #:_____ SS#:_____ Gender: Male Female

Relation to Patient:_____ Email Address:_____

Emergency Contact

Name:_____ Phone:_____ Relation to Patient:_____

Address:_____ City:_____ State:_____ Zip:_____

Patient Insurance Information

Primary Insurance Company's Name:_____

Name of Policy Holder:_____ DOB:_____

SS#:_____ Policy Holders Relationship to Patient:_____

Address:_____ City:_____ State:_____ Zip:_____

Secondary Insurance Company's Name:_____

Name of Policy Holder:_____ DOB:_____

SS#:_____ Policy Holder's Relationship to Patient:_____

Address:_____ City:_____ State:_____ Zip:_____

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INSTRUCTIONS: Please read the following carefully. Please sign a complete signature in the appropriate spaces. Please speak with our billing office if you have ANY questions.

Please present BOTH your insurance card(s) and your driver's license so we may make a copy for our records.
Anyone under 18 is a minor and MUST be accompanied by a parent/guardian.

Patient Name:_____ DOB:_____

I authorize treatment of the person named above and agree to be financially responsible for any balances not covered by my insurance carrier.

_____ _____ _____
Signature of Patient/Legal Guardian/Responsible Party Date Relationship to Patient

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Whitney Family Medicine to release any information necessary to process insurance claims and request payment of benefits to be made to Whitney Family Medicine for services rendered to my dependents or myself.

I understand that I am responsible at the time of service for paying any required co-payment and deductible.

I understand that if my insurance carrier requires that I designate an in-network Primary Care Provider ("PCP") in order to receive benefits as stated in my policy terms that I have chosen Randall Henderson, DO practicing at Whitney Family Medicine, 1314 N Brazos St., Whitney, TX 76692 as my PCP. I understand that some insurance policies do not provide out of network benefits.

I understand that if out of network benefits are not allowed under the terms of my insurance policy, and I see Dr. Henderson, or any other provider at Whitney Family Medicine, without confirming that the provider is an in-network provider, I am responsible for all charges accrued and will pay all amounts due no later than 60 days from the date of service.

FINANCIAL AGREEMENTS

I understand that if I fail to pay amounts owed to Whitney Family Medicine, the office has the right to secure an outside collection agency and/or attorney to collect the unpaid debt and to report the unpaid debt to a credit reporting agency. I further understand that I will be responsible for any additional charges or fees necessitated by securing the collection agency or attorney, including reasonable attorney's fees.

I understand that I can be charged a full fee for any appointment not canceled or for an appointment canceled with less than 24 hours' notice. Insurance policies generally will not pay for appointments not kept and understand that these charges will NOT be filed with my insurance.

If I have NO insurance coverage; I understand that I am responsible for payment of services rendered to my dependents or myself at the time of service.

There will be a $35.00 charge on ALL returned checks

_____ _____ _____
Signature of Patient/Legal Guardian/Responsible Party Date Relationship to Patient

_____ _____ _____
Printed Name of Legal Guardian/Responsible Party WFM Employee Signature Date

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Patient Name:_____ DOB:_____

AUTHORIZATION FOR EXAMINATION & TREATMENT: The undersigned has been informed of the examination and/or treatment considered necessary for the patient named on this record and that the treatment and procedures will be performed by Physicians and/or Physician Assistant/Nurse Practitioners of Whitney Family Medicine.

Authorization is hereby granted for such treatment and procedures and the administration of such local anesthetics, medications, or other treatment deemed necessary. I certify that I have read the above authorization and understand the same and certify that no guarantee or assurance has been made as to the results that may be obtained.

ACKNOWLEDGEMENT OF MID-LEVEL PRACTITIONER: I hereby acknowledge that this clinic staffs Mid-Level Practitioners (Physician's Assistant or Nurse Practitioner) to administer such treatment as is medically necessary. It is my right to choose to not be seen by the Mid-Level Practitioner.

ACKNOWLEDGEMENT OF OUTPATIENT TREATMENT: I hereby acknowledge that the medical care which may furnished to me in the outpatient room of the Whitney Family Medicine will be limited solely to outpatient treatment. I understand that I may be released before all my medical problems are known or treated and that it will be necessary for me to arrange for follow-up care.

INSURANCE BENEFITS: I hereby authorize and instruct my insurance carrier to make payment directly to Whitney Family Medicine for medical expense benefits otherwise payable to me. I understand that I am financially responsible to Whitney Family Medicine for charges made by them for services rendered.

CONSENT TO PERMIT TESTING AFTER A BLOOD OR BODY FLUID EXCHANGE: In the course of clinic care and treatment, healthcare workers may be accidentally exposed to a patient's blood or body fluids (through needle sticks, blood splatter, etc). Communicable disease, including HIV virus that causes AIDS, are known to be transmitted through accidental exposures of this type. When a healthcare worker is exposed to a patient's blood or body fluids, the patient must be tested for the HIV antibody and other communicable diseases in order to determine whether an actual exposure has occurred. This information is necessary so that the healthcare worker can receive appropriate counseling and medical treatment. I understand and agree that in the event a health care worker is exposed to my blood or body fluids, my blood will be tested at no cost to me, using a special coded system, for the HIV antibody. The results of these test may improve the course of medical treatment and will not prejudice my patient relationship with Whitney Family Medicine.

NOTICE OF POSSIBLE NON-COVERAGE: I understand that, in the opinion of Whitney Family Medicine, the services or items that have requested to be provided to me may not be covered by any insurance of the Texas Medical Assistance Program as being reasonable and necessary for my care. I understand that the Texas Department of Human Services or its health insuring agent determine the medical necessity of the services or items that I request and receive. I also understand that I am responsible for payment for the service items I requested and received if these services or items are determined not to be medically necessary for my care.

_____ _____ _____

Signature of Patient/Legal Guardian/Responsible Party | Date | Relationship to Patient

_____ _____ _____

Printed Name of Legal Guardian/Responsible Party | WFM Employee Signature | Date

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Patient Name:_____ DOB:_____

☐ Check here if neither of the following two (2) options apply

AUTHORIZATION TO TREAT A MINOR ☐ Not Applicable (patient is an adult)

(Ages 0-18th Birthday)

If there are circumstances when I am unable to bring my child to the office for his/her evaluation and treatment, I give my permission and authorization for the following persons (over the age of 18) to obtain medical care for my child. I also authorize the providers at Whitney Family Medicine to discuss or disclose information regarding any matters relating to my child's appointment, insurance, test results or medical care to those listed below. This authorization will remain in effect until I provide written notification to Whitney Family Medicine of changes or updates. I authorize Whitney Family Medicine to use the additional contact information listed below to discuss or disclose information regarding any matters relating to my appointments, insurance, billing information, test results and/or medical care.

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

☐ Not Applicable (patient is not on Medicare)

For MEDICARE patients only: Medicare #:_____

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Finance Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.) Regulations pertaining to Medicare assignment of benefits also apply.

Signature of Patient/Legal Guardian/Responsible Party	Date	Relationship to Patient

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BY SIGNING THIS FORM, YOU ARE STATING THAT YOU HAVE RECEIVED OR WERE NOTIFIED OF OUR **NOTICE OF PRIVACY ACTS** AS REQUIRED BY THE PRIVACY REGULATIONS CREATED AS A RESULT OF THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (**HIPAA**).

Patient Name:_____ **DOB:**_____

Signature of Patient/Legal Guardian/Responsible Party	Date	Relationship to Patient

Printed Name of Legal Guardian/Responsible Party	WFM Employee Signature	Date

MID-LEVEL PRACTITIONER CONSENT

Whitney Family Medicine has on staff a Mid-Level Practitioner (Physician Assistant or Nurse Practitioner) to deliver primary health care in the clinic setting.

A Mid-Level Practitioner (Physician Assistant or Nurse Practitioner) is not a doctor. A Mid-Level Practitioner (Physician Assistant or Nurse Practitioner) is a licensed healthcare professional who has received advanced education and training in the provision of primary health care. A Mid-Level Practitioner (Physician Assistant or Nurse Practitioner) can diagnose, treat, and monitor common acute and chronic diseases, provide health maintenance care as well as provide emergency care.

I have read the above and hereby consent to the services of a Mid-Level Practitioner (Physician Assistant or Nurse Practitioner) for my health care needs.

Patient Name: _____ DOB: _____

Signature of Patient/Legal Guardian/Responsible Party	Date	Relationship to Patient

Printed Name of Legal Guardian/Responsible Party	WFM Employee Signature	Date

*I have the right to refuse to see the Mid-Level Practitioner (Physician Assistant or Nurse Practitioner) and I am doing so by writing legibly REFUSED next to my signature.

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Patient Name: _____ DOB: _____

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Whitney Family Medicine to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by Whitney Family Medicine describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Whitney Family Medicine reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Whitney Family Medicine PO Box 2177 Whitney, TX 76692.

With this consent, Whitney Family Medicine may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Whitney Family Medicine may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

With this consent, Whitney Family Medicine may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Whitney Family Medicine restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Whitney Family Medicine to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the, practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Whitney Family Medicine may decline to provide treatment to me.
When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. My written revocation must be submitted to the privacy officer at: **Whitney Family Medicine, PO Box 2177, Whitney, TX 76692.**

***Optional*: In addition, I authorize disclosure of information regarding my billing, condition, treatment, and prognosis to the following individual(s)/family member/friend:**

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

This medical information may be used by the persons authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

This authorization shall be in force and effect until nine (9) months after my death or, _____ (date or event) at which time this authorization expires.

_____ _____ _____
Signature of Patient/Legal Guardian/Responsible Party Date Relationship to Patient

_____ _____ _____
Printed Name of Legal Guardian/Responsible Party WFM Employee Signature Date

TEXAS Health and Human Services | Texas Department of State Health Services

Texas Immunization Registry (ImmTrac2)

Adult Consent Form

(Please type or print clearly)

First Name _____ Middle Name _____ Last Name _____

Date of Birth (mm/dd/yyyy) ____/____/____ Gender: ☐ Male ☐ Female Telephone ____-____-____ Email address _____

Address _____ Apartment # / Building # _____

City _____ State _____ Zip Code _____ County _____

Mother's First Name _____ Mother's Maiden Name _____

Race (select all that apply)

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African-American
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other Race
☐ Recipient Refused

Ethnicity (select only one)

☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Recipient Refused

The Texas Immunization Registry (ImmTrac2) is a free service of the Texas Department of State Health Services (DSHS). The immunization registry is a secure and confidential service that consolidates and stores your immunization records. With your consent, your immunization information will be included in ImmTrac2. Doctors, public health departments, schools, and other authorized professionals can access your child's immunization history to ensure that important vaccines are not missed. For more information, see Texas Health and Safety Code Sec. 161.007 (d). https://statutes.capitol.texas.gov/Docs/HS/htm/HS.161.htm#161.007

Consent for Registration and Release of Immunization Records to Authorized Persons / Entities

EntitiesI understand that, by granting the consent below, I am authorizing release of my immunization information to DSHS and I further understand that DSHS will include this information in the Texas Immunization Registry. Once in ImmTrac2, my immunization information may by law be accessed by: a Texas physician, or other health care provider legally authorized to administer vaccines, for treatment of the individual as a patient; a Texas school in which the individual is enrolled; a Texas public health district or local health department, for public health purposes within their areas of jurisdiction; a state agency having legal custody of the individual; a payor, currently authorized by the Texas Department of Insurance to operate in Texas for immunization records relating to the specific individual covered under the payor's policy. I understand that I may withdraw this consent at any time by submitting a completed Withdrawal of Consent Form in writing to the Texas Department of State Health Services, Texas Immunization Registry.

State law permits the inclusion of immunization records for First Responders and their immediate family members in the Registry. A "First Responder" is defined as a public safety employee or volunteer whose duties include responding rapidly to an emergency. An "immediate family member" is defined as a parent, spouse, child, or sibling who resides in the same household as the First Responder. For more information, see Texas Health and Safety Code Sec. 161.00705. https://statutes.capitol.texas.gov/Docs/HS/htm/HS.161.htm#161.00705.

Please mark the appropriate box to indicate whether you are a First Responder or an Immediate Family Member.

☐ I am a FIRST RESPONDER. ☐ I am an IMMEDIATE FAMILY MEMBER (older than 18 years of age) of a First Responder.

By my signature below, I GRANT consent for registration. I wish to INCLUDE my information in the Texas immunization registry.

Individual (or individual's legally authorized representative):

Printed Name _____ Signature _____ Date _____

Privacy Notification: With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See *http://www.dshs.texas.gov* for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003, and 559.004)

Questions? (800) 252-9152 • (512) 776-7284 • www.ImmTrac.com

Texas Department of State Health Services • Immunizations • ImmTrac2 Group – MC 1946 • P. O. Box 149347 • Austin, TX 78714-9347

PROVIDERS REGISTERED WITH ImmTrac2: Please enter client information in ImmTrac2 and **affirm** that consent has been granted. **DO NOT fax to ImmTrac2. Retain this form in your client's record.**

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NEW PATIENT: COMPLETE THIS FORM TO AUTHORIZE YOUR PREVIOUS/OTHER PHYSICIAN(S) OR HOSPITAL(S) TO SEND COPIES OF YOUR HEALTH RECORDS TO WHITNEY FAMILY MEDICINE. (PLEASE USE ONE FORM FOR EACH PHYSICIAN/HOSPITAL - ADDITIONAL COPIES OF THIS FORM ARE AVAILABLE AT THE RECEPTION DESK).

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name	Date of Birth	SSN
Address		Telephone #

I authorize the use and disclosure of health information about me as described below:

Facility Authorized to **RECEIVE** my Health Information:
Whitney Family Medicine, 1314 N Brazos/PO Box 2177, Whitney, TX, 76692 Phone 254-694-3621 Fax 254-694-7436

Facility Authorized to **RELEASE** my Health Information; (YOUR OTHER DOCTOR/HOSPITAL)
Name:

Address:

Phone: Fax:

Health Information that may be used/disclosed is limited to the following:

☐ ENTIRE RECORD	☐ Consultations	☐ Treatment or Tests
☐ Lab Reports	☐ Imaging/X-Ray Reports	☐ Medical History & Physicals
☐ Allergy Records	☐ Immunization Reports	☐ Discharge Summary
☐ Surgical Reports	☐ Pathology Reports	

☐ Other (specify): _____

For the reasons below which require special permission to release otherwise privileged information, please release records pertaining to:

☐ Mental Health	☐ Developmental Disabilities	☐ Alcoholism
☐ HIV (AIDS)	☐ Sexually Transmitted Disease	☐ Drug Abuse
☐ Other (specify):		

For the Following Dates: _____

Health Information to be released to the above named agency/individual is to be used/disclosed for the following purposes: (Check applicable categories)

☐ Further Medical Care	☐ Legal Investigation for Action	☐ Personal
☐ Insurance Eligibility Benefits	☐ Changing Physicians	

Health Information identifies you (the patient) by name and includes other demographic information about you. Health Information may include, but is not limited to: medical records, x-ray films, slides, tracings, strips, etc.

I hereby discharge the releasing facility, its agents and employees from any and all liabilities, responsibilities, damages, and claims, which might arise from the release of information authorized herein, to include alcohol, drug abuse, communicable disease including HIV status, and/or psychiatric diagnoses compiled during my visit, encounter or hospitalization, or make copies thereof in accordance with the policies of this facility.

Protected Health Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by this privacy rule. If research-related Health Information is used or disclosed for continued research purposes, an expiration date or event does not apply.

This authorization will automatically expire 60 days after the date below (except as indicated above), unless an earlier date is specified, or at the conclusion of a specific event. I understand that I have a right to revoke this authorization at any time, in writing, as stated in the Notice of Privacy Practices, except where the facility has already made disclosures in reliance upon my prior authorization.

Treatment, payment, enrollment or eligibility for benefits may not be conditioned on obtaining an authorization if the Health Information Portability Accountability Act (HIPAA) prohibits such conditioning. If conditioning is permitted, refusal to sign the authorization may result in denial of care or coverage.

NOTICE TO RECEIVING AGENCY OR INDIVIDUAL: This information is to be treated in accordance with Health Information Portability Accountability Act (HIPAA) privacy regulations.

I UNDERSTAND THAT THERE MAY BE A CHARGE FOR THESE RECORDS AND THAT PAYMENT MUST BE MADE PRIOR TO THE COPYING OF THE REQUESTED RECORDS.

Patient's or Authorized Personal Representative's Signature X	Date	Time
Relationship to Patient/Authority to Act on Patient's Behalf	Interpreter, if utilized	
Witness Signature	Expiration Date or Event	

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PATIENT NAME: _____
DOB: _____ DATE: _____

REVIEW OF SYSTEMS

If you have trouble with any of the following check the box next to the problem(s). If you do NOT have any of the problem selections, check the "No Problem" box.

GENERAL:
☐Unusual weight changes
☐Fever
☐Fatigue
☐Weakness
☐Pain
☐No problem

SKIN:
☐Rashes
☐Dryness
☐Changes in skin, hair, or nails
☐No problem

EYES:
☐Pain
☐Excessive tearing
☐Dryness
☐Redness
☐Blurring Vision
☐Vision halos
☐Vision flashes
☐Eyestrain
☐No problem

EARS:
☐Drainage
☐Earache
☐Constant ringing
☐Hearing loss
☐No problem

NOSE:
☐Nosebleeds
☐Postnasal drip
☐Discharge
☐Sinus pain
☐No problem

MOUTH:
☐Gum soreness
☐Teeth condition
☐Tongue Pain
☐No problem

THROAT:
☐Hoarseness
☐Swelling
☐Trouble swallowing
☐No problem

URINARY:
☐Frequency or painful urinating
☐Pus in urine
☐Losing control of urine
☐Urinating at night
☐Blood in urine
☐No problem

LUNGS:
☐Shortness of breath
☐Cough
☐Coughing blood
☐Pneumonia
☐Wheezing
☐Phlegm/sputum
☐Pleurisy
☐Asthma
☐No problem

HEART & CIRCULATION:
☐Chest pain, tightness, pressure
☐Irregular heartbeat
☐Fast or slow heartbeat
☐Ankle swelling
☐Low blood pressure
☐High blood pressure
☐No problem

STOMACH, INTESTINES, & COLON:
☐Nausea
☐Vomiting
☐Vomiting blood
☐Change in bowel habits
☐Constipation
☐Diarrhea
☐Food intolerance
☐Rectal bleeding
☐Indigestion
☐Flatulence/passing gas
☐No problem

NERVOUS SYSTEM:
☐Fainting
☐Seizures/epilepsy
☐Tremors
☐Memory loss
☐Blackouts
☐Paralysis
☐Tingling of any part of body
☐Headaches
☐No problem

PSYCHOLOGICAL:
☐Depression
☐Loss of interest in activities that are normally enjoyed
☐Difficulty sleeping
☐Difficulty concentrating
☐Nervousness
☐Alcohol or drug abuse
☐No problem

MUSCLES, JOINTS, AND BONES:
☐Joint stiffness or pain
☐Backache
☐Limitation of joint or muscle movement
☐Joint swelling or redness
☐Muscle pain or cramps
☐Bone pain
☐No problem

BLOOD/ALLERGIES:
☐Anemia
☐Bleeding gums
☐Easy bruising or bleeding
☐Hives or welts
☐No problem

HORMONES:
☐Heat or cold intolerance
☐Excessive thirst, hunger, or urination
☐No problem

GENITALS (WOMEN):
☐Irregular periods
☐Very painful periods
☐Bleeding between periods
☐Sores
☐Vaginal discharge
☐Breast lump
☐Painful intercourse
☐No problem

GENITALS (MEN):
☐Sores
☐Groin swelling
☐Penile discharge
☐Hernias
☐Testicular pain or masses
☐Breast lump
☐Erection difficulties
☐No problem

PAST MEDICAL HISTORY: Please check any of the following conditions/ problems/diseases that you now have OR have been diagnosed with in the past

☐Abuse
☐Abnormal PAP
☐Alcoholism/drugs
☐Anemia
☐Anxiety/nerves
☐Arthritis
☐Asthma
☐Allergies
☐Bleeding disease
☐Blood transfusion
☐Blood clots
☐Cancer/tumor
☐Cholesterol (high)
☐Chronic pain
☐Depression
☐Diabetes/sugar
☐Epilepsy/seizures
☐Genetic diseases
☐Glaucoma/cataract
☐Gout
☐Headaches/migraines
☐Heart disease
☐Hepatitis (any)
☐High blood pressure
☐Intestinal disease
☐Kidney or bladder problems
☐Lung disease
☐Osteoporosis
☐Serious accident/injury
☐Sexual disease
☐Stroke
☐Thyroid disease
☐Tuberculosis
☐Ulcers/stomach disease

PAST SURGICAL HISTORY: List the year you had any of the following

_____Appendectomy
_____Blood transfusion
_____Hysterectomy
_____Gallbladder
_____Heart/Cath
_____Tubal/vasectomy
_____Hernia

Other: _____

Hospitalizations/Major trauma: List any major test or procedures done

CONTINUED ON NEXT PAGE

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Patient Name: _____ **DOB:** _____

ALLERGIES: ☐None ☐Antibiotics ☐Foods ☐Inhalants ☐Insects ☐Latex ☐Meds ☐Pollens ☐Skin ☐Transfusions ☐X-Ray contrast

Specify allergies: _____

_____

_____

HABITS: **Do you use (or have you used) any of the following:**

Tobacco: ☐Never ☐Now ☐Quit (year) _____ **Type used:** ☐Cigarettes ☐Pipe ☐Smokeless

Amount used per day: _____ How many years: _____

Alcohol: ☐Never ☐Social/Rare ☐Now ☐Quit (year) _____ **Type Used:** ☐Beer ☐Wine ☐Liquor

Amount used per week: ☐12 oz beers _____ ☐6 oz wine _____ ☐2 oz shots _____

How many years: _____

Drugs: ☐Never ☐Now ☐Quit (year) _____ **Type used:** ☐Pot ☐Cocaine ☐IV ☐Pain pills ☐Other (please specify) _____

Caffeine: (amount per day) ☐Coffee (cups) _____ ☐Tea (glasses) _____ ☐Soda (12 oz cans) _____

Exercise: ☐None per week ☐1-2 times per week ☐3-5 times per week ☐Everyday

Type of exercise: _____

FAMILY HISTORY

BLOOD RELATIVES	AGE, IF LIVING	AGE AT DEATH	MAJOR ILLNESS
Mother			
Grandmother			
Grandfather			
Father			
Grandmother			
Grandfather			
Brothers #			
Sisters #			
Children #			

CURRENT MEDICATIONS: List ALL medications that you take routinely or that have been prescribed for you by a doctor (including vitamins, over-the-counter medications, eye drops, herbal medications, etc.)

MEDICATION	DOSE/STRENGTH	MEDICATION DIRECTIONS

SPECIALISTS

SPECIALIST NAME	PHONE NUMBER	CONDITION TREATING

_____ _____

Patient Signature **Date**

_____ _____

Physician Signature **Date**