Please complete and return to the office prior to your appointment. Today's Date: ______________

Name: Last: _______________________, First: ____________________ MI: ___ Nickname: _________________

Date of Birth: _______________________ Age: _____ Sex: M F SSN: __________________________

Parent/Legal Guardian (if the patient is a minor):

Name: Last: ________________________, First: ________________________ Relation: __________________

Date of Birth: _________________________

Phone: Home: (_____) ______________ Work: (_____) _______________ Cell: (_____) _____________

Please initial if it is alright to leave a detailed message with health information

on your voicemail: _______

Home Address:

____

Street City State Zip

If married, please provide the following spouse information:

Name: ____ Date of Birth: __________________________

Address: ☐ Same as above or

____

Street City State Zip

Emergency Contact: ☐ Same as parent/guardian or _________________________ Relation: _______________

Phone: (_____) __________________ Alternative Phone: (_____) __________________

Address: ☐ Same as above or

____

Street City State Zip

Please list any persons you authorize the clinic to leave personal medical information with: (optional)

Name: ____ Relation: ________________________________

Name: ____ Relation: ________________________________

Primary Insurance: ____________________________ **Secondary Insurance:**________________________

Subscriber Name: ☐ Self or ____________________ Subscriber Name: ☐ Self or ___________________

Subscriber Date of Birth: ________________________ Subscriber Date of Birth: _____________________

Subscriber SSN: _________________________________ Subscriber SSN: _____________________________

Signature: ____ Date: ______________________________

East Texas Family Medicine

Patient Name: ________________________________ DOB: _______________ Today's Date: _____________

Past Medical History and Family History

Last Annual Wellness Exam: _________________

Most Important Concerns for this visit: 1. ____

2. ____

ALLERGIES to Medication: ☐ **Yes (detail below)** ☐ **No Known Drug Allergy**

Medication: _________________________ Reaction: ____

Medication: _________________________ Reaction: ____

Medication: _________________________ Reaction: ____

Other Allergies (please list): ____

MEDICATIONS: Please list all prescriptions and over-the-counter medications:

Prescriptions:

Medication	Dose	Instructions

(For additional items, please continues on back of this sheet)

Over-the-Counter Medications (non prescription):

Medication	Dose	Instructions

Supplements: Please list all herbal preparations and supplements that you take on a daily basis

Description	Amount taken daily

Preferred Pharmacy

Name: ____

Address: ____

Street City State Zip

Phone: (_____) ______________________________

East Texas Family Medicine

Patient Name: ________________________________ DOB: _______________ Today's Date: _____________

Do you have advanced directives? (Living Will, Durable Power of Attorney for medical decisions) ☐ Yes ☐ No

Please list other physicians and health care providers you see (specialists, therapists, counselors, chiropractors, etc):

Provider_____________________________ Reason ____
Provider_____________________________ Reason ____
Provider_____________________________ Reason ____
Provider_____________________________ Reason ____

PAST MEDICAL HISTORY: Please describe any condition that you have yourself:

Condition (Check all that apply)	Details (Year of Diagnosis, etc)
☐ Eye Disease or Cataracts	____
☐ Lung Disease	____
☐ Heart Disease	____
☐ Cancer	____
☐ Depression/Anxiety	____
☐ Mood Disorder	____
☐ Diabetes	____
☐ Digestive/stomach/GERD	____
☐ Bleeding or Clotting Disorders	____
☐ Hypertension	____
☐ Elevated Cholesterol	____
☐ Kidney Disease	____
☐ Sleep Apnea	____
☐ Thyroid Disease	____

☐ Other: ____

Previous Surgeries

Surgery	Details (Date, Complications, etc)
_________________________	____
_________________________	____
_________________________	____

Other Hospitalizations (include year and reason for admission:

____

____

East Texas Family Medicine

Patient Name: ________________________________ DOB: _______________ Today's Date: _____________

FAMILY MEDICAL HISTORY:

Father's Health Conditions: ____

Living? Y N If no, age of death ________

Mother's Health Conditions: ____

Living? Y N If no, age of death ________

Sibling's Health Conditions: ____

Other: ____

____

PERSONAL & SOCIAL HISTORY:

Do you smoke?

☐ No, I have never smoked.

☐ Yes, I smoke ___ packs of cigarettes a day for ___ years.

☐ No, I quit smoking ___ years ago. I smoked ___ packs a day for ___ years.

☐ Yes, I smoke cigars or a pipe, ___ a day for ___ years.

☐ Yes, I use smokeless tobacco ___ times a day for ___ years.

Describe current dietary limitations: ____

Who lives with you? ____

Occupation (indicate if retired): ____

Foreign travel outside of the U.S. in the past year ____

Additional information you would like for us to know about your health:

____

____

____

Previous Primary Care Physician: ____

Please tell us if you have had any of the following screening tests, and the most recent date:

Colonoscopy: ____

DEXA (bone density): ____

Women: Pap: ________________________________ Mammogram: ________________________________

Adult Immunizations:

Tetanus	☐ Yes	☐ No	Date:_________ Was pertussis included (Tdap)? ☐ Yes ☐ No
Pneumonia	☐ Yes	☐ No	Date:____
Hepatitis B	☐ Yes	☐ No	Dates (3 shots): _____________________________________
HPV	☐ Yes	☐ No	Dates (3 shots): _____________________________________
Zostavax	☐ Yes	☐ No	Date: ____

East Texas Family Medicine

Patient Name: _______________________________ DOB: _______________ Today's Date: _____________

Review of Systems (Current health symptoms):

1. Have you had a recent **weight gain or loss** that worries you? ☐ Yes ☐ No
2. Have you had any **unexplained fevers or night sweats**? ☐ Yes ☐ No
3. Do you have **sinus or nasal allergy symptoms** that affect your quality of life? ☐ Yes ☐ No
4. Do you have any **vision or hearing problems** that are bothersome? ☐ Yes ☐ No
5. Are you experiencing **chest pains or irregular beats** that worry you? ☐ Yes ☐ No
6. Do you have unusual **shortness of breath or a persistent cough**? ☐ Yes ☐ No
7. Do you have **leg swelling** that is recurrent or bothersome? ☐ Yes ☐ No
8. Do you experience **wheezing** when you breathe? ☐ Yes ☐ No
9. Do you have **sleep problems** that interferes with your quality of life? ☐ Yes ☐ No
10. Have you been told that you **snore and stop breathing during sleep**? ☐ Yes ☐ No
11. Do you have **constipation, diarrhea, stomach pain**, or other problems with digestion that interfere with your quality of life? ☐ Yes ☐ No
12. Have your **bowel movement patterns** changed in the recent months? ☐ Yes ☐ No
13. Do you have **problems with urination** that affect your quality of life? ☐ Yes ☐ No
14. Do you have **joint or back problems** that affect your quality of life? ☐ Yes ☐ No
15. Do you have **leg pain, numbness, or weakness** that limits how fast or far you can walk? ☐ Yes ☐ No
16. Do you have **headaches** that affect your ability to function? ☐ Yes ☐ No
17. Have you had an **unexpected fall with injury** in the past year? ☐ Yes ☐ No
18. Do you have **little pleasure** in your daily activities? ☐ Yes ☐ No
19. Do you feel **depressed or hopeless**? ☐ Yes ☐ No
20. Are you concerned about **anxiety or stress** in your life? ☐ Yes ☐ No
21. Are you concerned about your **memory**? ☐ Yes ☐ No

Comments: ____

____

____

Note: Evaluation of these concerns is not usually part of an annual wellness or preventative exam. It is likely that your doctor will need to schedule extra time or an additional appointment to follow up on these concerns.