For Office Use Only: ☐ Complete Physical ☐ Other

Name _____ DOB _____ Age _____ Today's Date _____

Preferred Name _____

Past Medical History

Current Medications & Dosages

Medication	Dosage	Medication	Dosage

What medications are you allergic to and what kind of reaction did you have? _____

_____

Do you take herbs or supplements? ☐ Yes ☐ No Which ones? _____

List all diseases you have or have had in the past:

☐ High Blood Pressure ☐ Elevated Cholesterol ☐ Cancer ☐ Diabetes ☐ Thyroid Disease ☐ Heart Disease

☐ Others _____

Hospital Admissions / Surgeries / Procedures / Biopsies

Year		Year	

Family History

Father: ☐ Living - Illness _____ ☐ Deceased - Cause of death _____ Age at death _____

Mother: ☐ Living - Illness _____ ☐ Deceased - Cause of death _____ Age at death _____

Has any parent, brother or sister had: (Please indicate which relative and approximate age at diagnosis)

(A.) ☐ Colon Cancer ☐ Ovarian Cancer ☐ Thyroid Cancer ☐ Heart Disease (before age 55 if male, or age 65 if female)
☐ Colon Polyps ☐ Prostate Cancer ☐ Breast Cancer ☐ Osteoporosis (bone thinning) ☐ Melanoma

(B.) ☐ Stroke ☐ Diabetes ☐ Bleeding Disorders ☐ Alcoholism
☐ Glaucoma ☐ Kidney Disease ☐ Arthritis ☐ Depression

Social History

Occupation _____ ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Domestic Partner # of Children _____

Alcohol: _____ drinks per week

Have you ever had problems with alcohol use? ☐ Yes ☐ No

Have you ever felt you needed to cut down on your drinking? ☐ Yes ☐ No

Have people annoyed you by criticizing your drinking? ☐ Yes ☐ No

Have you ever felt guilty about drinking? ☐ Yes ☐ No

Have you ever felt you needed a drink first thing in the morning (eye opener) to steady your nerves or to get rid of a hangover? ☐ Yes ☐ No

Do you smoke cigarettes? ☐ Yes How many packs per day? _____ For how many years? _____ ☐ No ☐ Quit, When ? _____

Do you chew tobacco or use snuff? ☐ Yes Tobacco or Snuff? _____ How much? _____ For how many years? _____ ☐ No ☐ Quit, When ? _____

Recreational Drug Use / Substance Abuse (injections or other): ☐ Yes ☐ No ☐ Past Which substances? _____

☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ Transgender Female ☐ Transgender Male ☐ Other

What type of exercise do you do? _____ How often? _____

Name:_____

☐ **REVIEW OF SYMPTOMS** Date:_____

CHECK ☑ THE BOX FOR CURRENT PROBLEMS

Your 3 Main Problems: (1) _____(2)_____(3)_____

General
- ☐ Fatigue/Weakness
- ☐ I do not feel rested when I wake up
- ☐ I am not satisfied with my sleep
- ☐ I am very sleepy during the day
- ☐ I fall asleep easily during the day
- ☐ Unhappiness
- ☐ Depression/Sadness
- ☐ Have felt down or hopeless for several months
- ☐ Have little interest/joy in usual activities
- ☐ Tearfulness
- ☐ Feelings of worthlessness
- ☐ Concentration difficulty
- ☐ Excessive irritability
- ☐ Lack of motivation
- ☐ Moodiness
- ☐ Nervousness/Anxiety
- ☐ Always feel ill
- ☐ Unexplained fever >100
- ☐ Frequent night sweats
- ☐ Weight loss - recent
- ☐ Weight gain
- ☐ Allergies
- ☐ Anemia
- ☐ Phobias
- ☐ Mental Illnesses

Skin
- ☐ I have a mole(s) I want you to check
- ☐ Changes in moles/unusual moles
- ☐ Are you concerned about skin spots/growths?
- ☐ Bruise easily
- ☐ Rashes
- ☐ Hives
- ☐ Itching
- ☐ Psoriasis
- ☐ Dry skin
- ☐ Excessive hair growth
- ☐ Hair Loss

Ears/Nose/Throat
- ☐ Allergy symptoms
- ☐ Frequent colds
- ☐ Decreased hearing
- ☐ Ringing in the ears
- ☐ Ear infections - frequent
- ☐ Dizzy spells - dizziness
- ☐ Nose Bleeds - frequent
- ☐ Sinus trouble
- ☐ Sore throat - frequent
- ☐ Hoarseness - frequent
- ☐ I would like allergy testing
- ☐ Non-healing mouth sores
- ☐ Childhood head/neck irradiation

Eyes
- ☐ Watery eyes
- ☐ Itchy eyes
- ☐ Eye Pain
- ☐ Double or blurred vision
- ☐ Other visual disturbances

Lungs
- ☐ Pneumonia
- ☐ Asthma/Wheezing
- ☐ Cough - persistent
- ☐ Coughing blood
- ☐ Snoring
- ☐ Stop breathing/gasp at night
- ☐ TB/Positive TB skin test

Heart/Circulation
- ☐ Shortness of breath
  - ☐ On exertion ☐ Lying flat
- ☐ Chest Pain or Chest Discomfort
- ☐ High blood pressure
- ☐ Heart Murmur
- ☐ Palpitations/Racing heart
- ☐ Irregular pulse
- ☐ Fainting spells
- ☐ Swollen ankles
- ☐ Leg pain with walking
- ☐ Varicose veins
- ☐ Cold/Numb feet
- ☐ Phlebitis – Blood clots

Gastrointestinal
- ☐ Change in bowel habits - recent
- ☐ Indigestion or heartburn
- ☐ Loss of appetite - recent
- ☐ Difficulty swallowing
- ☐ Persistent nausea/vomiting
- ☐ Peptic ulcers
- ☐ Swallowing pain
- ☐ Abdominal pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Bloody or tarry stools
- ☐ Hemorrhoids
- ☐ Gallbladder problems
- ☐ Hepatitis/Jaundice
- ☐ Require laxative – How often?

Genital/Urinary
- ☐ Hernia
- ☐ Urine infections - frequent
- ☐ Painful urination
- ☐ Frequent urination
- ☐ Urinary leakage/Incontinence
- ☐ Blood in urine
- ☐ Overnight urination x 2
- ☐ Loss of control of urination
- ☐ History of sexually transmitted diseases?
- ☐ Are there sexual issues or dysfunctions you want to discuss?
- ☐ Loss of interest in sex

Male
- ☐ Decrease in force of urination
- ☐ Erection problems
- ☐ Too rapid ejaculation
- ☐ Testicle lumps/swelling

Female
- ☐ Pain/Bleeding during or after sex
- ☐ Vaginal discharge/itching
- ☐ Abnormal Pap smear
- ☐ Flushing/Menopause symptoms
- ☐ Significant pain/cramps with periods

Breast
- ☐ Pain
- ☐ Cysts
- ☐ Lumps/Nodules
- ☐ Nipple discharge
- ☐ Biopsy of a nodule/lump

Female Menstrual History

Age of Onset _____ ☐ Reg ☐ Irreg ☐ Menopause

Flow: ☐ Heavy ☐ Moderate ☐ Light

_____Days of flow _____ Length of cycle

# of pregnancies _____

# of live births _____

# of miscarriages/other _____

Birth control method _____

Central/Peripheral Nervous System
- ☐ Headaches - frequent
- ☐ Seizures/convulsions
- ☐ Stroke
- ☐ Memory loss
- ☐ Tremor/Hands shaking
- ☐ Dizzy/Lightheaded
- ☐ Muscle wasting
- ☐ Numbness/Tingling sensations

Musculoskeletal
- ☐ Arthritis
- ☐ Back pain - recurrent
- ☐ Bone pain/fracture
- ☐ Gout
- ☐ Foot pain

Miscellaneous

Date of last tetanus booster shot_____

Have you ever been physically hurt by your partner?

☐ Yes ☐ No

Blood transfusion before 1992? ☐ Yes ☐ No

I want sexually transmitted disease testing ☐ Yes ☐ No

I want HIV testing ☐ Yes ☐ No

Frequent foreign travel? ☐ Yes ☐ No

I would like more information on
- ☐ Allergy testing
- ☐ Participating in Research Studies

Other

Other diseases or symptoms or concerns

_____

_____

_____

Explanation: _____

_____

Note to MD or PA: Write "P" next to any symptom discussed on Progress Note (P = see PN)

FAMILY MEDICINE ASSOCIATES OF TEXAS, PA

Thank you for selecting our healthcare team. We will strive to provide you with the best possible healthcare. To help us meet your needs, please fill out this form completely. You will be asked to update this information every twelve(12) months due to our changing healthcare environment. We will also ask you for a copy of your Insurance Card(s) and a copy of your Driver's License.

Today's Date _____ Date of Birth _____ Preferred Name _____

Patient Last Name _____ First Name _____ Middle _____

Address _____ City/State/Zip _____

Person responsible for payment _____ Patient relationship to responsible party _____

Address _____ Phone # _____

City/State/Zip _____

Primary Phone (_____) ☐OK to leave message on machine with detailed appointment / medical information

_____ ☐OK to leave message with our office name and call back number only

Secondary Phone (_____) ☐OK to leave message on machine with detailed appointment / medical information

_____ ☐OK to leave message with our office name and call back number only

Email Address _____

Emergency Contact _____ Relationship _____ Phone _____

How were you referred to our office? ☐Friend ☐Family ☐Facebook ☐Twitter ☐Insurance ☐Print Ad

Referring Doctor or Facility _____ Other _____

Explanation of Complete Physical

The physical will be performed in two parts. The first part includes blood tests and a discussion with your doctor of medical problems and symptoms you may be having. The office visit and non-routine blood work will be billed under a medical diagnosis. The second part of the physical will include review of your test results. If you are treated for a medical condition during your physical, non-routine fees will be submitted separately from the routine complete physical.

You may wish to contact your insurance company to see if routine benefits are covered. The company may have a maximum dollar limit for routine care. Your physician cannot always be sure that the cost will be under that dollar amount. Our staff can discuss acceptable payment arrangements for any of these services.

Waiver for possible Non-Covered Service

Routine/preventative services to include but not limited to complete physicals, school, sports, and camp physicals, travel counseling, immunizations, pap smears, well child appointments, and flu shots may not be covered by your insurance company.

I understand that my insurance company may or may not cover these services or labs being performed today. Some insurance companies may pay a portion and others may not cover these services at all. If you have a large deductible, some or all of this may go to your deductible. I understand this and I am willing to be responsible for charges not covered by insurance.

_____ _____

Signature (Patient/Guardian) Date