DOCTORS CLINIC HOUSTON
Medical & Occupational Medicine Specialists

Today's Date: _____

PATIENT INFORMATION FORM

Patient's Name: _____ (Last Name) _____ (First Name) ____ (MI) is patient a minor? ☐ No ☐ Yes

Social Security Number: _xxx-xx-_____ Gender: Male ☐ Female ☐ Date of Birth (mm/dd/yyyy): _____

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

Primary Phone: _____ Cell Phone: _____ E-mail: _____

Emergency Contact Name: _____ Relationship: _____ Phone: _____

Pharmacy Name/Location: _____ Phone: _____

Employer/School: _____ Phone: _____

Is treatment requested related to an accident? ☐ Yes ☐ No If Yes: ☐ Auto ☐ Work ☐ Other: _____

Date of Injury (mm/dd/yyyy): _____ Explain accident/injury: _____

_____

Health Insurance

Bring you Health Insurance Cards with you for your visits

Your Group Insurance Carrier: _____ Effective Date: _____

Carrier Address (back of Card): _____ City: _____ State: _____ Zip: _____

Insured's Name: _____ Insured's Date of Birth (mm/dd/yyyy): _____

Insured's Soc. Sec. #: _xxx-xx-_____ Plan #: _____

Employer of Insured: _____ Phone: _____

Patient relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Supplement/Secondary Carrier: _____ Member ID: _____

Is this an Auto Related Injury? ☐ Yes ☐ No If Yes, please complete this section:

Name of your Auto Insurance: _____ Policy #: _____ Effective Date: _____

Adjuster's Name: _____ Phone: _____ Claim #: _____

Name of OTHER Driver's Auto Insurance: _____ Effective Date: _____

Adjuster's Name: _____ Phone: _____ Claim #: _____

Is this a Work Related Injury? ☐ Yes ☐ No If Yes, please complete this section:

Your Employer: _____ Contact's Name: _____

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

Signature: _____ Print Name & Relationship to Patient _____ Date _____

HEALTH HISTORY QUESTIONNAIRE

Marital Status:

☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed

How did you hear about us?

☐ Internet search ☐ Insurance directory ☐ Referred by patient ☐ other _____

Date of Last Physical Exam: _____ Date of last Pap smear: _____

PATIENT CONDITION

Is the condition worse? ☐ Yes No ☐

How often do you have this pain/condition? _____

Does it interfere with your work, sleep and daily routine? ☐ Yes No ☐

Rate your pain on a scale from 1 (least pain) to 10 (severe pain)? _____

Activities that are painful to perform? ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lifting

What treatment have you already received for your condition? ☐ Medication ☐ Surgery ☐ Physical Therapy

Please list all of the medications that you are taking. Include over the counter medications and herbs.

Medication Name	Dose	Last Taken		Medication Name	Dose	Last Taken

Allergies to Medications: ☐ Yes ☐ No

Name of Drug: _____ Reactions you had: _____

HEALTH HABITS AND PERSONAL SAFETY

Exercise:

☐ Sedentary (No exercise) ☐ Mild Exercise (i.e., climb stairs, walk 3 blocks, golf)

☐ Occasional Vigorous Exercise (i.e., work or recreation less than 4x/week for 30 min.)

☐ Regular Vigorous Exercise (i.e., work or recreation 4x/week for 30 minutes)

Diet:

Are you dieting? ☐ Yes ☐ No

If yes, are you on a physician prescribed medical diet? ☐ Yes ☐ No

# of meals you eat in an average day?_____

Rank Salt Intake: ☐ Hi ☐ Med ☐ Low Rank Fat Intake ☐ Hi ☐ Med ☐ Low

Caffeine	☐ None ☐ Coffee ☐ Tea ☐ Cola # of Cups/Cans Per Day?

Alcohol:

Do you drink alcohol? ☐ Yes ☐ No

How many drinks per week? _____

Have you considered stopping? ☐ Yes ☐ No

Have you ever experienced blackouts? ☐ Yes ☐ No

Are you prone to "binge" drinking? ☐ Yes ☐ No

Do you drive after drinking? ☐ Yes ☐ No

Tobacco:

Do you use tobacco? ☐ Yes ☐ No

☐ Cigarettes - Pks/day ☐ Chew - #/day ☐ Pipe - #/day

☐ Cigars - #/day ☐ # of Years ☐ or Year Quit

Drugs:

Do you currently use recreational or street drugs? ☐ Yes ☐ No

Have you ever given yourself street drugs with a needle? ☐ Yes ☐ No

List any Medical Problems that other Doctors have diagnosed:

Surgeries:		
Year	***Reason***	***Doctor/Hospital***

Other Hospitalizations:		
Year	**Reason**	**Hospital**

FAMILY HISTORY

		Age	Age at Death	Significant Health Problems or Cause of Death			Age	Age at Death	Significant Health Problems or Cause of Death
Father					Children	☐ M ☐ F			
Mother						☐ M ☐ F			
Brothers & Sisters	☐ M ☐ F					☐ M ☐ F			
	☐ M ☐ F					☐ M ☐ F			
	☐ M ☐ F				Grandparents (Mother's side)	☐ M ☐ F			
	☐ M ☐ F					☐ M ☐ F			
	☐ M ☐ F				Grandparents (Father's side)	☐ M ☐ F			
	☐ M ☐ F					☐ M ☐ F			

OTHER PROBLEMS

☐ Weight: Unintentional weight loss or gain

☐ Depression/Anxiety or suicide attempts

☐ Trouble sleeping, snoring during sleep or suffering from sleep apnea

☐ Any hot flashes or sweating at night?

☐ Skin: Any rashes or suspicious skin lesions

☐ Ears: Decreased hearing, ear pain or drainage

☐ Eyes: Do you have vision loss?

☐ Nose: Nasal congestion, bleeding, drainage or injury

☐ Throat: Frequent sore throat, hoarseness

☐ Mouth: Sore tongue, bleeding gums, tooth decay
Date of last dental exam:_____

☐ Head: Headaches, head injury, swollen glands

☐ Do you have frequent fall or lose your balance?

☐ Back: Pain, stiffness, decreased movement

☐ Leg pain with numbness or tingling sensation and heel pain

☐ Neck or shoulder pain

☐ Arms, hands pain, numbness or tingling sensation

☐ Bladder: Burning with urination, increased frequency in urination, blood in urine, change in urinary stream, urinary incontinence

☐ Heart: Heart problems, high blood pressure, rheumatic fever, murmurs

☐ Lungs: Difficulty breathing, frequent cough, asthma, bronchitis, TB

☐ Intestines: Problems swallowing, diarrhea, constipation, decreased appetite, nausea, vomiting, gas, rectal bleeding, change in stool

Other pain/Discomfort:

Patient Name _____ DOB _____ Date _____/_____/_____

Patient Disclaimer

The health care provider may recommend you get services more often than your insurance covers, or they may recommend services that your insurance doesn't cover even though we participate with them. If this happens, you may have to pay some or all of the costs for medical services performed. It is important to ask questions so you understand why your provider is recommending certain services and whether the insurance will pay for them.

I accept financial responsibility for any services not covered by my insurance.

Patient Signature: _____ Date: _____

Assignment Release:

I authorize Texas Medical Alliance Group to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim. I understand that I will be financially responsible to Texas Medical Alliance Group for any and all charges not covered by insurance.

Notice of Privacy Practice:

I acknowledge that I was provided with the notice of Privacy Practices of Texas Alliance Medical Group and informed that a copy can be provided at my request.

I attest that the above information is true to the best of my knowledge.

Patient Signature _____ Date _____