

PEARLAND HEALTH CARE

PATIENT INFORMATION

Last name: _____ First: _____ MI: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Work: _____ Cell: _____
Date of Birth: _____ M F Marital Status: M D S W
Social Security: _____ Drivers License: _____
Employer: _____ Address: _____
City: _____ State: _____ Zip: _____

WHOM TO CALL IN EMERGENCY

Name: _____
Phone: _____ Relationship: _____

PARENT/SPOUSE INFORMATION

Last name: _____ First: _____ MI: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Work: _____ Cell: _____
Date of Birth: _____ Social Security: _____
Drivers License: _____ Employer: _____

INSURANCE INFORMATION

Policy Holder: _____ Relation to Patient: _____
Address: _____ City: _____ State: _____ Zip: _____
Date of Birth: _____ Social Security: _____ M F
Employer: _____ Phone: _____
Primary Insurance Co: _____
ID#: _____ Group#: _____ Phone: _____
Secondary Insurance: _____
ID#: _____ Group#: _____ Phone: _____

Patient Name : _____ DOB : _____

PATIENT RECORD DISCLOSURES

In general, the HIPAA Privacy Rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

- Home Telephone _____
 - OK to leave message with detailed information – we cannot leave detailed information on an answering machine if your answering machine message does not indicate your name.
 - Leave message with call back number only
- Work Telephone _____
 - OK to leave message with operator/secretary/receptionist for call back
 - Leave message with call back number only
 - OK to leave message with detailed information – we cannot leave detailed information if your voice mail does not indicate your name.
- Written Communication
 - OK to mail to my home address
 - OK to mail to my work/office address
 - OK to FAX to this number _____
 - OK to email to this address _____
- Other _____

Patient Signature

Date

Witness

Date

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of PHI and requests for PHI be limited to the minimum necessary to accomplish the intended purpose. These provision do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Note – Uses and disclosures may be permitted without prior consent in an emergency.

Record of Disclosures

Date	Disclosed to Whom Address or FAX #	(1)	Description of Disclosure & Purpose	By Whom Disclosed	(2)	(3)

Record of Disclosures

- (1) Check this box if disclosure is authorized
- (2) Disclosure Type
T=Treatment Records P=Payment Information O=Healthcare Operations A=Authorization on File D=Discretionary
- (3) Disclosure Route
F=FAX P=Phone E=Email M=Mail O=Other

Original Date: 10/25/2003
Dates Revised:

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name: M F DOB
(Last, First, M.I.)

Marital Status: Single Partnered Married Separated Divorced Widowed

Previous or Referring Doctor: Date of Last Physical Exam:

PERSONAL HEALTH HISTORY

Childhood Illness: Measles Mumps Rubella Chicken Pox Rheumatic Fever Polio

Immunizations and Dates: Tetanus Pneumonia
 Hepatitis Chicken Pox
 Influenza MMR
Measles, Mumps, Rubella

List Any Medical Problems That Other Doctors Have Diagnosed:

Surgeries:

Year	Reason	Hospital

Other Hospitalizations:

Year	Reason	Hospital

Have you ever had a blood transfusion? Yes No

Continued on Back Side

MENTAL HEALTH

- Is stress a major problem for you? Yes No
- Do you feel depressed? Yes No
- Do you panic when stressed? Yes No
- Do you have problems with eating or your appetite? Yes No
- Do you cry frequently? Yes No
- Have you ever attempted suicide? Yes No
- Have you ever seriously thought about hurting yourself? Yes No
- Do you have trouble sleeping? Yes No
- Have you ever been to a counselor? Yes No

WOMEN ONLY

- Age at onset of menstruation: Date of last menstruation:
- Period every days. Heavy periods, irregularity, spotting, pain, or discharge?..... Yes No
- Number of pregnancies Number of live births
- Are you pregnant or breastfeeding? Yes No
- Have you had a D&C, hysterectomy, or Cesarean section? Yes No
- Any urinary tract, bladder, or kidney infections within the last year? Yes No
- Any blood in your urine? Yes No
- Any problems with control of urination? Yes No
- Any hot flashes or sweating at night? Yes No
- Do you have menstrual tension, pain, bloating,
irritability, or other symptoms at or around time of period? Yes No
- Experienced any recent tenderness, lumps, or nipple discharge? Yes No
- Date of last pap smear and rectal exam?

MEN ONLY

- Do you usually get up to urinate during the night? Yes No If yes, # of times
- Do you feel pain or burning with urination? Yes No
- Any blood in your urine? Yes No
- Do you feel burning discharge from penis? Yes No
- Has the force of your urination decreased? Yes No
- Have you had any kidney, bladder, or prostate infections within the last 12 months? Yes No
- Do you have any problems emptying your bladder completely? Yes No
- Any difficulty with erection or ejaculation? Yes No
- Any testicle pain or swelling? Yes No
- Date of last prostate and rectal exam?

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

- Skin
- Head/Neck
- Ears
- Nose
- Throat
- Lungs
- Chest/Heart

- Back
- Intestines
- Bladder
- Bowels
- Circulation
- Recent Changes In:**
- Weight.

- Energy Level
- Ability to Sleep
- Other Pain/Discomfort:**

Sex: Are you sexually active? Yes No
 If yes, are you trying for a pregnancy? Yes No
 If not trying for a pregnancy, list contraceptive or barrier method used
 Any discomfort with intercourse? Yes No

Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness? Yes No

Personal Safety: Do you live alone? Yes No
 Do you have frequent falls? Yes No
 Do you have vision or hearing loss? Yes No
 Do you have an Advance Directive and/or Living Will? Yes No
 Would you like information on the preparation of these? Yes No

Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider? Yes No

Please remember that the following recommendations are very important to maintaining your health.

When in a car, wear your safety belt at all times.

While riding a motorcycle or bicycle, wear a helmet.

Always have functional smoke detectors and fire extinguishers in your home.

If you own a firearm, make sure that it is accessible only to you. Take every precaution to ensure that children do not have access to a loaded firearm.

Keep the firearm and ammunition in separate locations.

FAMILY HEALTH 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	<input type="checkbox"/> M <input type="checkbox"/> F		
Mother					<input type="checkbox"/> M <input type="checkbox"/> F		
Brothers and Sisters	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F			Grandparents (Mother's Side)			
	<input type="checkbox"/> M <input type="checkbox"/> F			<i>Male</i>			
	<input type="checkbox"/> M <input type="checkbox"/> F			<i>Female</i>			
	<input type="checkbox"/> M <input type="checkbox"/> F			Grandparents (Father's Side)			
	<input type="checkbox"/> M <input type="checkbox"/> F			<i>Male</i>			
	<input type="checkbox"/> M <input type="checkbox"/> F			<i>Female</i>			

Continued on Back Side

List Your Prescribed Drugs and Over-the-Counter Drugs, Such as Vitamins and Inhalers:

Name of Drug	Strength	Frequency Taken
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Allergies to Medications:

Name of Drug	Reaction You Had
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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? _____

All questions contained in this questionnaire are optional and will be kept strictly confidential.

Alcohol: Do you drink alcohol? Yes No
 If yes, what kind? _____ How many drinks per week? _____
 Are you concerned about the amount you drink? Yes No
 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

All questions contained in this questionnaire are optional and will be kept strictly confidential.

Drugs: Do you currently use recreational or street drugs? Yes No
 Have you ever given yourself street drugs with a needle? Yes No

All questions contained in this questionnaire are optional and will be kept strictly confidential.

