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: *(Last, First, M.I.)* ☐ M ☐ F	**DOB**
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
☐ Hepatitis
☐ Influenza
☐ Pneumonia
☐ Chicken Pox
☐ 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 breast 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	☐ Back	☐ Energy Level
☐ Head/Neck	☐ Intestines	☐ Ability to Sleep
☐ Ears	☐ Bladder	**Other Pain/Discomfort:**
☐ Nose	☐ Bowels	
☐ Throat	☐ Circulation	
☐ Lungs	**Recent Changes In:**	
☐ Chest/Heart	☐ Weight	

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
Father			
Mother			
Brothers and Sisters	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		

	Age	Age at Death	Significant Health Problems or Cause of Death
Children	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
	☐ M ☐ F		
Grandparents (Mother's Side)			
Male			
Female			
Grandparents (Father's Side)			
Male			
Female			

Continued on Back Side

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

Name of Drug	Strength	Frequency Taken

Allergies to Medications:

Name of Drug	Reaction 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?

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.