

# 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
<b>Father</b>				<b>Children</b>	<input type="checkbox"/> M <input type="checkbox"/> F		
<b>Mother</b>					<input type="checkbox"/> M <input type="checkbox"/> F		
<b>Brothers and Sisters</b>	<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			<b>Grandparents (Mother's Side)</b>			
	<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			<b>Grandparents (Father's Side)</b>			
	<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

**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.*

