WOODLANDS FAMILY PRACTICE PATIENT INFORMATION

Date:____/____/_____

Patient Name:_____ Marital Status _____

Date of Birth:____/____/_____ Social Security #: _____

Address:_____ City:_____ State:___ Zip Code:_____

Primary Contact #: _____-_____-_____ Secondary Contact #: _____-_____-_____

FOR ADULT PATIENTS ONLY:

Patient Employer:_____ Occupation:_____

Business Address:_____ Business #: _____-_____-_____

Name of Spouse:_____ Date of Birth: ____/____/_____

Spouse Primary #: _____-_____-_____ Spouse Secondary #: _____-_____-_____

Spouse Employer:_____ Occupation:_____

Business Address:_____ Business #: _____-_____-_____

FOR CHILDREN UNDER 18

Father's Name: _____ Date of Birth: ____/____/_____

Home Address: _____ Social Security #: _____

Primary Contact #: _____-_____-_____ Secondary Contact #: _____-_____-_____

Employer: _____ Work #: _____-_____-_____

Mother's Name: _____ Date of Birth: ____/____/_____

Home Address: _____ Social Security #: _____

Primary Contact #: _____-_____-_____ Secondary Contact#: _____-_____-_____

Employer: _____ Work #

FOR ALL PATIENTS

Emergency Contact Name:_____ Relationship to Patient:_____

Primary Contact #: _____-_____-_____ Secondary Contact #: _____-_____-_____

AUTHORIZATION: I hereby authorize the physician to furnish information to insurance carriers concerning this illness/accident and 1 hereby irrevocably assign to the doctor all payments for medical services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance.

Signature _____

INITIAL VISIT

Patients Name: _____ Date:_____/_____/_____

Past Medical History
List any medical problems:

1.

2.

3.

4.

5.

6.

7.

Past Surgical History
List any past surgeries with dates:

1.

2.

3.

4.

5.

Family History
Medical problems in your family:

Father:

Mother:

Brother(s):

Sister(s):

Allergies
List any allergies to medicines:

Medications
List all current medications with dosages
(ex. Lisinopril 10mg once a day)

Social History

What do you like to do for fun?

Do you smoke? How much?

Do you drink alcohol? How much?

Pharmacy

Name:

Location:

Phone:

Fax:

REVIEW OF SYSTEMS

Date:_____

Please fill this out for all initial patient visits (adult and children). If this is for a child or a minor, please have a parent or guardian complete the form.

1. **Constitutional** Any change in weight in the past 6 months?
   How is your general health?

2. **Eyes** Any problems with your vision?
   Any redness or drainage from your eyes?

3. **Ears, Nose, Throat** Any ear pain or discharge?
   Any oral sores/lesions?

4. **Cardiovascular** Any chest pain? (if so, at rest or with exertion?)
   Do you wake up at night short of breath?

5. **Respiratory** Any shortness of breath? (if so, how often and what brings it on?)
   Any wheezing?

6. **GI** Any abdominal discomfort? (heartburn, excessive gas or burping?)
   Any blood in your stool?

7. **Musculoskeletal** Any aches or pains? Any swollen joints?

8. **Neuro** Any loss of strength? Any loss of sensation?

9. **GU** Any vaginal or penile discharge?
   Any pain during urination?

10. **Skin** Any rashes or skin problems?
    Any blisters or non-healing sores?

11. **Endocrine** Any increase in thirst? Any increase in urination?
    Any heat intolerance or cold intolerance?

12. **Psych** Any lack of pleasure in activities that you used to enjoy?
    Any problems with depressed mood?

13. **Vaccinations** Are you up to date on flu, pneumonia (if applicable), and tetanus?

PATIENT AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION TO DESIGNATED REPRESENTATIVES(S)

I,_____, give my authorization to release my protected health information including results of my laboratory tests, x ray and/or other test results to the following designated representative(s):

Patient Initials

_____ My spouse (Name) _____

_____ My child (Name) _____

_____ Other (Name) _____

_____ Personal Representative

_____ Results may be left on my answering machine at home.

_____ Results may be left on my answering machine at work.

_____ Results may be mailed to my home address.

_____ Results may be left on my cell phone. Cell # _____

_____ **May not be given to anyone other than myself.**

** **STAT** results will be delivered by phone only.

_____ _____

Patient Signature: Date:

_____ _____

Witness: Date:

As a patient, you have the right to revoke this authorization in writing at anytime, except to the extent that action has been taken in reliance on this authorization or, if applicable, during a contestability period. In order for the revocation of this authorization to be effective, Woodlands Family Practice must receive the revocation in writing. The revocation must include, 1) the patient's name, address, and date of birth, 2) the patient's desire to revoke the authorization, and 3) the date of the revocation and the patient's signature. All revocations must be sent in writing to Woodlands Family Practice 1055 Evergreen Circle, Spring, TX 77380 or faxed to (281) 363-1643 and will not be considered effective until received by our office.