## Family Medicine Clinic & Medical Weight Loss Clinic

813 South Amy Lane Ste 101 Harker Heights, TX, 76548 Phone: 254-699-8521

Today's Date:
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Reason for Visit:

	PATIEN	JT IN	FORMA	TION			
Full Name:						Birth Date:	
Social Security Number:		□ M	□ F	Marital Status:			
Address:	I			<u> </u>			
Race: 🗆 African-American 🗆 American Ind	lian/Alaskan	Native	🗆 Asiai	n 🗆 Native	Hawaiian/P	Pacific Islander	□ White
Ethnicity: 🗆 Hispanic/Latino 🛛 Not Hispanic	/Latino		La	anguage:	□ Englisł	n 🗆 Spanish	□ Other
C	OMMUNIC	ATIO	N PREF	ERENCES			
Home Phone: Cel	l Phone:				Work Phone:		
Email Address: (for statements and patient pol	rtal)						
How Would You Like to Receive Appointment			Text Mes	ssage 🗆	Ma Email	y we leave deta □Yes □No	ailed voicemails?
	EMER	GENC	Y CONT	ACT			
Name: Relationship to Patient:							
rimary Phone: Secondary Phone:			□ You can speak with this person in detail about my healthcare.				
Names of other individuals that FPE may spea	ak to about n	ny hea	lthcare:		-		
	I	NSUR	ANCE				
YOU MUST SUBMIT PHOTO C				FRONT & E	ACK) WIT	TH YOUR PACE	КЕТ
Primary Insurance:				<u> </u>	ID#:		
Secondary Insurance:					ID#:		
	<b>GUARAN</b>	TOR I	NFORM	IATION	1		
Name: Relationship to Patient:							
Address:			Da	Date of Birth:			
Phone:							
By signing below, I am acknowledging	the follow	ing:					
• I have reviewed the information above fo	or correctness	and ha	ive made	any and all cl	nanges nece	essary.	

- I hereby authorize and consent to examinations, treatments, and release of medical information to insurance companies, claim representatives, adjusters, and other physicians necessary to process claims and assign to the physician payment for services.
- A copy of the Notice of Privacy Practices for Family Physicians of Evans has been made available to me on the website and in the office. I have been provided with an opportunity to ask questions regarding the Notice and its contents.

# Patient Health History Questionnaire

**PATIENT INFORMATION** 

Full Name:

Birth Date:

Today's Date:

**REASON FOR VISIT** 

	ALLERGIES	PAST HOSPITALIZATIONS/SURGERIES			
Туре	Reaction	Description	Date		
i.e. Latex	Rash				

#### **CURRENT MEDICATIONS**

## You must list ALL of your medications that you take regularly.

# If you do not provide a complete medication list here, we may decline to establish a physician-patient relationship.

NAME	DOSAGE	FREQUENCY	REASON
.e. Advil	200mg	2 tablets once a day	Back pain

PREFERRED PHARMACIES								
N	Name			Location				
Local								
Mail Order								
		CURRENT N	MEDICAL PROBLEMS					
□ Anxiety	□ Anxiety □ Depression		🗆 Diabetes	🗆 Heart	t Problems			
□ High Blood Pressure □ High Cholestero		sterol	🗆 Lung Problems	Thyre	oid Problems			
□ Other:								
	SPECIAL	ISTS/OTHE	ER HEALTHCARE PROVID	ERS				
Previous Primary Care -			OB/GYN -					
Cardiology -			Urology -					
Dermatology -			Oncology -					
Endocrinology -			Ophthalmology -					

Other Providers -

Note         Provider/Location         Results           Colonoscopy	HEALTH MAINTENANCE							
Pap Smear       Ammogram         Mammogram       SA (Prostate Screen)         PSA (Prostate Screen)       SA (Prostate Screen)         EXA (Bone Density Test)       SA (Prostate Screen)         Eye Exam       Pneumovia         -       Pneumovia         -       Pneumovia         -       Previar         Flu Shot       Shingles Shot         Tetanus Shot       Shingles Shot         Tetanus Shot       Shingles Shot         Breast Cancer       Y       N         Colon Cancer       Y       N         Biabetes       Y       N         Osteoporosis       Y       N         Biabetes       Y       N         Stroke       Y       N         Stroke       Y       N         Biabetes       Y       N         Stroke       Y       N	When was your last Date		Date	Provider/Location		Results		
Mammogram       SA (Porstate Screen)	Colonoscopy							
PSA (Prostate Screen)	Pap Smear							
DEXA (Bone Density Test)	Mammogram							
Eye Exam	PSA (Prostate Scr	een)						
Pneumonia Shot	DEXA (Bone Dens	ity Test)						
	Eye Exam							
Prevnar Flu Shot Shingles Shot Tetanus Shot	Pneumonia Shot							
Flu Shot	- Pneumov	ax						
Shingles Shot   Tetanus Shot   Tetanus Shot   Do you have a family history of   Who?   Do you have a family history of   Who?   Breast Cancer   Y   N   Colon Cancer   Y   N   Diabetes   Y   N   Diabetes   Y   N   Diabetes   Y   N   Diabetes   Y   N   Anxiety/Depression   Y   N   Heart Attack   Y   N   Heart Attack   Y   N   Heart Attack   Y   N   Anxiety/Depression   Y   N   Anxiety/Depression   Y   N   Broack   Y   N   Anxiety/Depression   Y   N   Anxiety/Depression   Y   N   Broack   Y   N   Stocke   Y   N   Stocke   Y   N   No, Never   Pres, Cigarettes   O you drink alcohol?   No   Pres   Do you currently exercise?   No   Yes   No   Yes   No   Yes   No   Yes   No	- Prevnar							
FAMILY HISTORY         FAMILY HISTORY         Do you have a family history of       Who?         Breast Cancer       Y       N       Colon Cancer       Y       N         High Cholesterol       Y       N       Prostate Cancer       Y       N         Diabetes       Y       N       Prostate Cancer       Y       N         Diabetes       Y       N       Prostate Cancer       Y       N         Heart Attack       Y       N       Anxiety/Depression       Y       N         Heart Attack       Y       N       Psych/drug/alcohol problems       Y       N         Stroke       Y       N       Psych/drug/alcohol problems       Y       N         Breast Cancer       Y       N       Psych/drug/alcohol problems       Y       N         Breast Cancer       Y       N       Psych/drug/alcohol problems       Y       N         Heart Attack       Y       N       Psych/drug/alcohol problems       Y       N         Stroke       Y       N       No       Psych/drug/alcohol problems       Y       N         Do you currently use tobacco or nicotine?       No, Never       Yes, Cigarettes								
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Breast Cancer Y N   High Cholesterol Y N   Prostate Cancer Y N   Diabetes Y N   Osteoporosis Y N   Breart Attack Y N   Heart Attack Y N   Anxiety/Depression Y N   Heart Problems Y N   Anxiety/Depression Y N   Heart Attack Y N   Anxiety/Depression Y N   Heart Problems Y N   Anxiety/Depression Y N   Heart Problems Y N   Anxiety/Depression Y N   Never Y N   Stroke Y N   No, Never Yes, Cigarettes   You do use tobacco or nicotine? No, Normer Smoker   Yes, Cigars Yes, Cigars   No, Former Smoker Yes, Smokeless Tobacco   Yes, E-Cig/Vape I   If you do use tobacco, how often/how much do you use?   Do you currently exercise? No   Yes - How Much/Often?   Do you currently exercise? No   Yes - Type of Exercise?   How Often?   What is your marital status?   Single   Divorced   What is you marital status?   No   Yes - Where?   Do you attend religious service?   No   Yes - Where?   Do you attend religious service?   No   Yes - Wher				-				
High Cholester I I I   High Cholester I I I   High Cholester I I I   Diabetes I I I   Heart Attack Y I N   Heart Attack Y I N   Heart Attack Y I N   Heart Problems Y I N   Heart Problems Y I N   Stroke I I N   Meart Problems Y I N   Stroke I N Psych/drug/alcohol problems Y   N Psych/drug/alcohol problems Y N   Stroke Y N Psych/drug/alcohol problems Y   N N Psych/drug/alcohol problems Y N   Stroke Y N Psych/drug/alcohol problems Y   N No Never Italian Yes, Cigarettes Yes, Cigars   Do you currently use tobacco or nicotine? No, Never Yes, Smokeless Tobacco Yes, Cigars   If you do use tobacco, how often/how much do you use? I am interested in quitting   Do you drink alcohol? No Yes - Type of Exercise? How Often?   What is your marital status? Single Divorced Widowed Separated Married   Do you have children? No Yes - Where? Image: Comparison of the second of the		-	-	Wh	0?		-	Who?
In grin diction of the second sec								
Heart Attack Y N   Heart Attack Y N   Heart Attack Y N   Heart Problems Y N   Stroke Y N   Stroke Y N   O you currently use tobacco or nicotine? No, Never Yes, Cigarettes   No, Former Smoker Yes, Smokeless Tobacco Yes, Cigars   No, Former Smoker Yes, Smokeless Tobacco Yes, E-Cig/Vape   If you do use tobacco, how often/how much do you use? I am interested in quitting   Do you currently exercise? No Yes - How Much/Often?   Do you currently exercise? No Yes - Type of Exercise?   How dityou in your home? Image: Comparison of the image								
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Stroke Y N   High Blood Pressure   Y N   SOCIAL HISTORY Do you currently use tobacco or nicotine?   No, Never Yes, Cigarettes   No, Former Smoker Yes, Smokeless Tobacco   Yes, E-Cig/Vape   If you do use tobacco, how often/how much do you use?   If you do use tobacco, how often/how much do you use?   If you do use tobacco, how often/how much do you use?   I am interested in quitting   Do you currently exercise?   No   Yes - How Much/Often?   Do you currently exercise?   No   Yes - Type of Exercise?   How Often?   What is your marital status?   Single   Divorced   What is your marital status?   Single   Divorced   Widowed   Separated   Married   Engaged   What are you employed?   No   Yes - Where?   What are your hobbies? How did you hear about our practice?								
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How did you hear about our practice?	Do you attend religious services?  No  Yes - Where?							
	What are your hobbies?							
Do we currently see any of your family members? If so, what are their names?	How did you hear about our practice?							