



MY PERSONAL PHYSICIAN REGISTRATION FORM

(Please Print)

Today's date:				
PATIENT INFORMATION				
Patient's Last Name:		First:	Middle:	Nickname:
Birth date:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Age:	*Social Security no.:	
Street address:			Home phone no.: ()	
City:	State:	Zip:	Cell phone no.: ()	
Occupation:	Employer:		Employer phone no.: ()	
Preferred Pharmacy:			Pharmacy Phone number: ()	
Children seen here:				
*Email address>>				

BILLING INFORMATION		
Person responsible for bill:	Address (if different):	Phone no.: ()
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No		

HEALTH HISTORY QUESTIONNAIRE

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

NAME: <i>(Last, First, M.I.):</i>		<input type="checkbox"/> M <input type="checkbox"/> F	DOB:
MARITAL STATUS: <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			
PREVIOUS OR REFERRING DOCTOR:		DATE OF LAST PHYSICAL EXAM:	
PERSONAL HEALTH HISTORY			
CHILDHOOD ILLNESS: <input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rubella <input type="checkbox"/> Chickenpox <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Polio			
Immunizations/Dates:	<input type="checkbox"/> Tetanus		<input type="checkbox"/> Pneumonia
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?			<input type="checkbox"/> Yes <input type="checkbox"/> No

Please turn to next page

PREFERRED PHARMACY:	PHONE NUMBER:
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List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name the Drug	Strength	Frequency Taken

ALLERGIES TO MEDICATIONS

Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	<input type="checkbox"/> Sedentary (No exercise) <input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf) <input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.) <input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)		
Diet	Are you dieting?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, are you on a physician prescribed medical diet?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	# of meals you eat in an average day?		
	Rank salt intake	<input type="checkbox"/> Hi <input type="checkbox"/> Med <input type="checkbox"/> Low	
	Rank fat intake	<input type="checkbox"/> Hi <input type="checkbox"/> Med <input type="checkbox"/> Low	
Caffeine	<input type="checkbox"/> None <input type="checkbox"/> Coffee <input type="checkbox"/> Tea <input type="checkbox"/> Cola		
	# of cups/cans per day?		
Alcohol	Do you drink alcohol?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, what kind?		
	How many drinks per week?		
	Are you concerned about the amount you drink?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you considered stopping?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever experienced blackouts?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Are you prone to "binge" drinking?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you drive after drinking?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Tobacco	Do you use tobacco?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes – pks./day	<input type="checkbox"/> Chew - #/day	<input type="checkbox"/> Pipe - #/day <input type="checkbox"/> Cigars - #/day
	<input type="checkbox"/> # of years	<input type="checkbox"/> Or year quit	

Drugs	Do you currently use recreational or street drugs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have you ever given yourself street drugs with a needle?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sex	Are you sexually active?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, are you trying for a pregnancy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If not trying for a pregnancy list contraceptive or barrier method used:		
	Any discomfort with intercourse?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Personal Safety	Do you live alone?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have frequent falls?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have vision or hearing loss?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have an Advance Directive or Living Will?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Would you like information on the preparation of these?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

FAMILY HEALTH HISTORY

		AGE	SIGNIFICANT HEALTH PROBLEMS			AGE	SIGNIFICANT HEALTH PROBLEMS
FATHER				Children	<input type="checkbox"/> M		
MOTHER					<input type="checkbox"/> F		
Sibling	<input type="checkbox"/> M				<input type="checkbox"/> M		
	<input type="checkbox"/> F			<input type="checkbox"/> F			
	<input type="checkbox"/> M			<input type="checkbox"/> M			
	<input type="checkbox"/> F			<input type="checkbox"/> F			
	<input type="checkbox"/> M			GRAND MOTHER			
	<input type="checkbox"/> F			<i>Maternal</i>			
	<input type="checkbox"/> M			GRAND FATHER			
	<input type="checkbox"/> F			<i>Maternal</i>			
<input type="checkbox"/> M			GRAND MOTHER				
<input type="checkbox"/> F			<i>Paternal</i>				
<input type="checkbox"/> M			GRAND FATHER				
<input type="checkbox"/> F			<i>Paternal</i>				

MENTAL HEALTH

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

 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 mammogram?

Date of last colonoscopy?

Date of last pap 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 colonoscopy?

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.

<input type="checkbox"/> Skin	<input type="checkbox"/> Chest/Heart	<input type="checkbox"/> Recent changes in:
<input type="checkbox"/> Head/Neck	<input type="checkbox"/> Back	<input type="checkbox"/> Weight
<input type="checkbox"/> Ears	<input type="checkbox"/> Intestinal	<input type="checkbox"/> Energy level
<input type="checkbox"/> Nose	<input type="checkbox"/> Bladder	<input type="checkbox"/> Ability to sleep
<input type="checkbox"/> Throat	<input type="checkbox"/> Bowel	<input type="checkbox"/> Other pain/discomfort:
<input type="checkbox"/> Lungs	<input type="checkbox"/> Circulation	

NAME: _____**DATE:** _____

SYMPTOM QUESTIONNAIRE

PLEASE CIRCLE ALL CURRENT SYMPTOMS OR COMPLAINTS WHICH APPLY TO YOU:

SKIN	RESPIRATORY	GENITOURINARY
HIVES RASHES ECZEMA	DIFFICULTY BREATHING	URINARY FREQUENCY
PALLOR DERMATITIS LUMPS	DIFFICULTY WHEN LYING DOWN	INABILITY TO HOLD URINE
BRUISING PSORIASIS ACNE	SHORTNES OF BREATH	HESITANCY DURING URINATION
BRITTLE NAILS /RIDGING OF NAILS	COUGHING UP BLOOD	BURNING PAIN UPON UIRINATION
FUNGAL INFECTIONS OF NAILS	CHRONIC COUGH	FREQENT NIGHT URINATION
FREQUENT ITCHING	BRONCHIAL ASTHMA	BLOOD IN URINE
	WHEEZING	URINARY TRACT INFECT.
HEAD	SPUTUM PRODUCTION	BLADDER INFECTIONS
HEADACHES MIGRAINES	CARDIOVASCULAR	KIDNEY INFECTIONS
DIZZINESS FAINTING	IRREGULAR RHYTHM	KIDNEY STONES
CONVULSIONS	HEART MURMUR	YEAST INFECTIONS
SLEEPINESS AFTER MEALS	HIGH BLOOD PRESSURE	SYPHILIS / GONORRHEA/ HERPES
FEELING OF FULLNESS IN HEAD	CHEST PAIN PALPITATIONS	TRICHOMONAS
PRONE TO HAIR LOSS	RAPID HEART BEAT	WOMEN – VAGINAL DISCHARGE
	DATE/RESULT LAST EKG:	MEN – PENILE DISCHARGE/
EYES		MEN - IMPOTENCE
DRYNESS EYES WATERY EYES	DATE/RESULT OTHER CARDIAC	MUSCULAR / SKELETAL
DOUBLE VISION ITCHY EYES	TESTS:	CHRONIC FATIGUE OSTEOARTHRITIS
BLURRED VISION DISCHARGE	GASTROINTESINAL	MUSCLE ACHES / PAINS / WEAKNESS
GLAUCOMA CATARACTS	LOW / EXCESSIVE APPETITE	JOINT ACHES / PAINS / SWELLING
DATE OF LAST EYE EXAM:	WT. CHANGE + _____ / - _____ LBS.	LEG CRAMPS WHEN WALKING
	YELLOW JAUNDICE FLAUTULENCE	LEG CRAMPS AT NIGHT
SURGERIES:	HEMORRHOIDS RECTAL BLEEDING	RHEUMATOID ARTHRITIS
EARS	CONSTIPATION ABDOMINAL CRAMPS	OSTEOPOROSIS
FREQUENT ACHES /INFECTIONS	BLOATING AFTER MEALS DIARRHEA	COLOR CHANGE IN:
EAR DRAINAGE ITCHY EARS	VOMITING BLOOD NAUSEA/VOMITING	FINGERS OR HANDS OR FEET
HEARING LOSS	COLITIS RECTAL POLYPS	NUMBNESS OR TINGLING IN:
FEELING OF FULLNESS IN EARS	DIFFICULTY SWALLOWING	FINGERS OR HANDS OR FEET
SURGERIES:	HEPATITIS: TYPE	SLEEP PATTERN
NOSE	DATE LAST GI SERIES	DIFFICULTY FALLING ASLEEP
POST NASAL DRIP POLYPS	DATE LAST COLONOSCOPY	DIFFICULTY STAYING ASLEEP
CHRONIC SINUSITIS STUFFINESS	DATE LAST SIGMOIDOSCOPY	FREQUENT AWAKENINGS
NOSE BLEEDS RUNNY NOSE	DATE ENDOSCOPY	NIGHT SWEATS
SURGERIES:	DATE SONOGRAM	NIGHTMARES
THROAT & MOUTH	ANY OTHER GI EXAMS	ANY OTHER SYMPTOMS / CONCERNS
FREQENT SORE THROATS		
HOARSNES ENLARGED NODES		
GAGGING SORE TONGUE		
CANKER SORES GUM DISEASE		
VOICE CHANGES ITCHY PALATE		
EXTENSIVE DENTAL WORK		

LIST OF PHYSICIANS

Name: _____
Specialty: _____
Address: _____
Phone: _____
Fax: _____

Name: _____
Specialty: _____
Address: _____
Phone: _____
Fax: _____

Name: _____
Specialty: _____
Address: _____
Phone: _____
Fax: _____

Name: _____
Specialty: _____
Address: _____
Phone: _____
Fax: _____

Name: _____
Specialty: _____
Address: _____
Phone: _____
Fax: _____

HIPAA

**AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION
IN ACCORDANCE WITH 45 CFR 164.509-HIPAA**

I hereby authorize _____ to disclose my Protected Health Information (PHI) as contained in the records maintained by _____, including but not limited to highly confidential information concerning communicable diseases, HIV, AIDS, psychiatric, chemical or alcohol dependency, laboratory test results, or any other medical treatment. This authorization does not include psychotherapy notes.

PATIENT IDENTIFICATION INFORMATION

Patient's name _____
Last First Middle

Social Security Number _____ Date of Birth _____

Name and address of recipient: My Personal Physician
1110 Austin Highway
SAN ANTONIO, TX 78209

(210) 826-3700 FAX (210) 826-3747

DESCRIPTION OF INFORMATION TO BE RELEASED

Please initial the materials to be released pursuant to this authorization:

- any and all medical records/reports consultation report other
- immunization records summary sheet
- test results (lab/radiology)

This authorization includes the release of documents in your possession whether or not created in your office or by another healthcare provider.

This authorization is in effect from _____ to _____. Upon conclusion of said period, this authorization is automatically revoked.

I understand that the information released in response to this authorization is subject to disclosure to other parties, and that any other person, firm, or entity that releases material pursuant to this authorization is released from any liability that might otherwise result from the release of this information.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the physician or appropriate healthcare provider. I understand that the revocation will not apply to information that has already been released in response to this authorization.

I understand authorization for the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment. I further understand that my healthcare and the payment of my healthcare will not be affected if I do not sign this form.

Patient, the patient's personal representative
Or patient's guardian (if the patient is a minor or incapacitated adult)

Date