MY PERSONAL PHYSICIAN
REGISTRATION FORM
(Please Print)

Today's date:				
PATIENT INFORMATION				
Patient's Last Name: First: Middle:				Nickname:
Birth date:	Sex: ❑ M ❑ 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? ❑ Yes ❑ No		

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 ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio		
Immunizations/Dates:	☐ Tetanus	☐ 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?	☐ Yes	☐ No

Please turn to next page

PREFERRED PHARMACY:	**PHONE NUMBER:**	
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	☐ 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?					
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				

Drugs	Do you currently use recreational or street drugs?	☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?	☐ Yes	☐ No
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 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

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
FATHER			**Children**	☐ M ☐ F	
MOTHER				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**GRAND MOTHER** *Maternal*		
	☐ M ☐ F		**GRAND FATHER** *Maternal*		
	☐ M ☐ F		**GRAND MOTHER** *Paternal*		
	☐ M ☐ F		**GRAND FATHER** *Paternal*		

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?	☐ 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.

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ 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 COLONSCOPY	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		
HOARSNESS 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 Date
Or patient's guardian (if the patient is a minor or incapacitated adult)