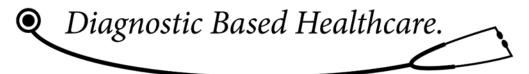
# FAMILY MEDICINE AUSTIN



Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please approximate. Add any notes you think are important. ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL. Main reason for today's visit: Other concerns: ALLERGIES: List anything that you are allergic to (medications, food, bee stings, etc.) and how each affects you. 2. \_\_\_\_\_ **MEDICATIONS** Please list all the medications you are taking. Include prescribed drugs and over-the-counter drugs, such as vitamins and inhalers. DRUG NAME STRENGTH FREQUENCY TAKEN 3. \_\_\_\_\_ **IMMUNIZATION HISTORY** Immunizations and most recent date: □ Chickenpox □ Meningococcus Date: \_\_\_\_\_ □ MMR (Measles, Mumps, Rubella) Date: \_\_\_\_\_ ☐ Flu Shot ☐ Gardasil/HPV □ Pneumonia □ Tdap (*Tetanus and pertussis*) □ Hepatitis A

□ Tetanus

□ Zostavax (Shingles)

Date:

□ Hepatitis B

### (WOMEN ONLY) OBSTETRIC AND GYNECOLOGICAL HISTORY

Last PAP Smear Last Mammogram Age of first menstrual per Date of last menstrual per Number of pregnancies: miscarriages:  Cesarean sections	eriod: b b a		□ Wake in the nigh □ Hot flashes □ Painful lump or n □ Painful intercoun □ Sexually active Current partner Do you use cond	ual pain ourning, or discharge at to go to the bathroom nipple discharge rse is □ Female □ Male		
		PAST MEDICAL HIST	ORY			
Please check all that ap	ply:					
☐ Anxiety Disorder	· -	Diverticulitis	□ Kidney	Disease		
□ Arthritis		Fibromyalgia	□ Kidney	Stones		
□ Asthma		Gout	□ Leg/Fo	oot Ulcers		
☐ Bleeding Disorder		Has Pacemaker	□ Liver D	Disease		
☐ Blood Clots (or DVT)		Heart Attack	□ Osteop	oorosis		
□ Cancer		Heart Murmur	□ Polio			
□ Coronary Artery Disease □ Hiatal Hernia or Refle		Hiatal Hernia or Reflux Disease	☐ Pulmonary Embolism			
□ Claustrophobic □ HIV or AIDS		HIV or AIDS		□ Reflux or Ulcers		
□ Diabetes - Insulin		High Cholesterol	□ Stroke			
□ Diabetes - Non-Insulin		High Blood Pressure	□ Tubero	culosis		
□ Dialysis		Overactive Thyroid	□ Other			
		PAST SURGICAL HIST	<u> </u>			
SURGERY	REASON		YEAR	HOSPITAL		
1	<del></del>					
2						
3.						

#### **FAMILY HEALTH HISTORY**

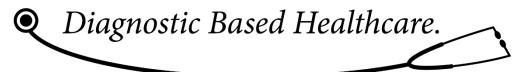
RELATION	ALIVE?	AGE	SIGNIFICA	ANT HEALTH PROE	BLEMS			
<b>Grandmother</b> (maternal)	Y/N			lism □ Arthritis Disease □ Hyperto	•			netic disease
<b>Grandfather</b> (maternal)	Y/N			lism □ Arthritis Disease □ Hyperto	•			netic disease
<b>Grandmother</b> (paternal)	Y/N			lism 🗆 Arthritis Disease 🗆 Hyperto	•			netic disease
<b>Grandfather</b> (paternal)	Y/N			lism 🗆 Arthritis Disease 🗆 Hyperto	•			netic disease
Father	Y/N			lism □ Arthritis Disease □ Hyperto	•			netic disease
Mother	Y/N			lism □ Arthritis Disease □ Hyperto	•			netic disease
Brother/Sister	Y/N			lism □ Arthritis Disease □ Hyperto	•			netic disease
Brother/Sister	Y/N			lism □ Arthritis Disease □ Hyperto	•			netic disease
Other	Y/N			lism □ Arthritis Disease □ Hyperto	•			netic disease
SOCIAL HISTORY								
Education    High school	□ Less tha	an 8 <sup>th</sup> grade	Caffeine	□ None □ Moderate	<ul><li>□ Occasional</li><li>□ Heavy</li></ul>		If not current tobacco?	ly, did you ever use □ Yes □ No
<ul><li>□ 2 year college</li><li>□ Post graduate</li></ul>	□ 4 year o	college		# of cups/cans pe	r day?		<ul><li>□ Cigarettes -</li><li>□ Chew</li><li>□ Cigars</li></ul>	
Marital Status  □ Divorced  □ Domestic partne		d □ Single ted □ Widowed	Alcohol	Do you drink alco  Yes No If so, how often?  Occasionally	hol?  □ < 3 times/w	<b>Drugs</b> rk	□ # of years _ Or year quit _	  ntly use recreational or
Exercise Level	□ Occasio	no exercise) onal exercise ate exercise vel exercise		□ > 3 times/wk How many drinks	per week?	_	If yes, list:	
	•		Tobacco	Do you use tobac	co?			

□ Yes □ No

#### **REVIEW OF SYSTEMS**

Please check all the apply:			
Allergic/Immunologic	Ear/Nose/Mouth/Throat	Genitourinary	Neurologica
☐ Frequent Sneezing	□ Bleeding Gums	□ Blood in Urine	□ Dizziness
□ Hives	□ Difficulty Hearing	□ Difficulty Urinating	□ Fainting
□ Itching	□ Dry Mouth	☐ Incomplete Emptying	□ Headaches
□ Runny Nose	□ Ear Pain	□ Increased Urinary Frequency	☐ Memory Loss
□ Sinus Pressure	☐ Frequent Infections	☐ Urinary Loss of Control	☐ Migraines
Cardiovascular	☐ Frequent Nosebleeds	Hematologic/Lymphatic	□ Numbness
☐ Arm Pain on Exertion	□ Hoarseness	□ Easy Bruising/Bleeding	□ Restless Legs
☐ Chest Pain on Exertion	□ Mouth Breathing	□ Swollen Glands	□ Seizures
☐ Chest Heaviness/Pressure on	☐ Mouth Ulcers	Integumentary (Skin)	Psychiatric
Exertion	□ Nose/Sinus Problems	☐ Change in Moles	□ Alcohol Overuse
☐ Irregular Heart Beats (Palpitations)	□ Ringing in Ears	□ Dry Skin	□ Anxiety/Stress
□ Known Heart Murmur	Endocrine	□ Eczema	☐ Do Not Feel Safe in
☐ Light-headed on Standing	□ Fatigue	☐ Growth/Lesions	Relationship
☐ Shortness of Breath When Lying	☐ Increased Thirst/Hunger/Urination	□ Itching	□ Mania
Down	Gastrointestinal	□ Jaundice (Yellow Skin/Eyes)	□ Sleep Problems
☐ Shortness of Breath When Walking	□ Abdominal Pain	□ Rash	Respiratory
☐ Swelling (edema)	□ Black or Tarry Stool	Musculoskeletal	□ Cough
Constitutional	☐ Blood in Stool	□ Back Pain	□ Coughing Up Blood
☐ Exercise Intolerance	☐ Change in Appetite	□ Joint Pain	☐ Shortness of Breath
□ Fatigue	☐ Frequent Indigestion	☐ Muscle Aches	□ Sleep Apnea
□ Fever	□ Hemorrhoids	☐ Muscle Weakness	□ Snoring
□ Weight Gain (lbs)	□ Trouble Swallowing	□ Wheezing	
☐ Weight Loss (Ibs)	□ Vomiting		
Eyes	□ Vomiting Blood		
□ Dry Eyes			
□ Irritation			
□ Vision Change			
Date of Last Exam:			
Please add any other information abo	ut your health that you would like your	provider to know here:	
	<del></del>		
Parent, Guardian, or Caregiver Signatu	ıre	Date	

# FAMILY MEDICINE AUSTIN



#### PATIENT CONTACT AUTHORIZATION

PLEASE NOT THAT PRACTICE DOES NOT DISCLOSE OR SELL ANY PATIENT PROTECTED HEALTH INFORMATION TO ANY THIRD-PARTY BUSINESS OR ONLINE DATABASE.

I, the undersigned, authorize Family Medicine Austin ("Practice") to contact me according to the policies of Practice regarding facets of my care, including requests for information, verification of payment or benefits, or reminders for appointments. I understand and accept that Practice may leave messages on my home or cell phone answering system or send reminder cards by U.S. mail, email, or text message according to the policies of Practice.

If Practice needs to communicate with me regarding my treatment, my preferred method of communication is as follows (check one): □ Phone call \_\_\_\_ □ Email \_\_\_\_ □ Text message \_\_\_\_ □ Other I understand that if I have chosen a phone call as my preferred method of communication, Practice may be required to leave a voicemail for me regarding my treatment. In such an event, Practice should (check one): □ Leave a voicemail with detailed information regarding my treatment. ☐ Leave a message requesting that I call Practice at a specified phone number. I understand that from time-to-time Practice may utilize email or text messages to communicate with me both about my treatment and for marketing purposes. I understand that these emails or text messages may include appointment reminders, general health reminders, feedback requests, newsletters, and other information relating to Practice. Accordingly, I (check one): ☐ Authorize Practice to **email** me for both treatment and marketing purposes. ☐ Authorize Practice to **email** me for appointment and health reminders only. □ Authorize Practice to **text** me for both treatment and marketing purposes. □ Authorize Practice to **text** me for appointment and health reminders only.

□ Do not authorize Practice to email or text me.

Printed Patient Name	Date	Signature of Patient
9		officers, and staff are released from any legal responsibility or of my health or billing information.
written notice of revocation to P or unsubscribe options included		), Austin, TX; call Practice at (512) 872-6868; or utilize the opt-out message or email contacts.
		in effect until I either submit a subsequent Patient Contact or I revoke this authorization in writing. To do so, I must send

Representative/Witness