FAMILY MEDICINE AUSTIN

Diagnostic Based Healthcare.

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.

ALLERGY	REACTION
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____

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
1. _____	1. _____	1. _____
2. _____	2. _____	2. _____
3. _____	3. _____	3. _____
4. _____	4. _____	4. _____
5. _____	5. _____	5. _____

IMMUNIZATION HISTORY

Immunizations and most recent date:

□ Chickenpox	Date: _____	□ Meningococcus	Date: _____
□ Flu Shot	Date: _____	□ MMR *(Measles, Mumps, Rubella)*	Date: _____
□ Gardasil/HPV	Date: _____	□ Pneumonia	Date: _____
□ Hepatitis A	Date: _____	□ Tdap *(Tetanus and pertussis)*	Date: _____
□ Hepatitis B	Date: _____	□ Tetanus	Date: _____
		□ Zostavax *(Shingles)*	Date: _____

(WOMEN ONLY) OBSTETRIC AND GYNECOLOGICAL HISTORY

Last PAP Smear Date: _____ □ Abnormal
Last Mammogram Date: _____ □ Abnormal
Age of first menstrual period: _____
Date of last menstrual period: _____
Number of pregnancies: _____ births: _____
miscarriages: _____ abortions: _____
□ Cesarean sections If yes, then number: _____

□ Bleeding between periods
□ Heavy periods
□ Extreme menstrual pain
□ Vaginal itching, burning, or discharge
□ Wake in the night to go to the bathroom
□ Hot flashes
□ Painful lump or nipple discharge
□ Painful intercourse
□ Sexually active
Current partner is □ Female □ Male
Do you use condoms? □ Yes □ No
Other Birth control method used: _____
□ Interested in being screened for STD'

PAST MEDICAL HISTORY

Please check all that apply:

□ Anxiety Disorder
□ Arthritis
□ Asthma
□ Bleeding Disorder
□ Blood Clots (or DVT)
□ Cancer
□ Coronary Artery Disease
□ Claustrophobic
□ Diabetes - Insulin
□ Diabetes - Non-Insulin
□ Dialysis
□ Diverticulitis
□ Fibromyalgia
□ Gout
□ Has Pacemaker
□ Heart Attack
□ Heart Murmur
□ Hiatal Hernia or Reflux Disease
□ HIV or AIDS
□ High Cholesterol
□ High Blood Pressure
□ Overactive Thyroid
□ Kidney Disease
□ Kidney Stones
□ Leg/Foot Ulcers
□ Liver Disease
□ Osteoporosis
□ Polio
□ Pulmonary Embolism
□ Reflux or Ulcers
□ Stroke
□ Tuberculosis
□ Other

PAST SURGICAL HISTORY

SURGERY	REASON	YEAR	HOSPITAL
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

FAMILY HEALTH HISTORY

RELATION	ALIVE?	AGE	SIGNIFICANT HEALTH PROBLEMS
Grandmother (maternal)	Y/N	_____	□ Alcoholism □ Arthritis □ Depression □ Cancer □ Diabetes □ Genetic disease □ Heart Disease □ Hypertension □ Osteoporosis □ Stroke
Grandfather (maternal)	Y/N	_____	□ Alcoholism □ Arthritis □ Depression □ Cancer □ Diabetes □ Genetic disease □ Heart Disease □ Hypertension □ Osteoporosis □ Stroke
Grandmother (paternal)	Y/N	_____	□ Alcoholism □ Arthritis □ Depression □ Cancer □ Diabetes □ Genetic disease □ Heart Disease □ Hypertension □ Osteoporosis □ Stroke
Grandfather (paternal)	Y/N	_____	□ Alcoholism □ Arthritis □ Depression □ Cancer □ Diabetes □ Genetic disease □ Heart Disease □ Hypertension □ Osteoporosis □ Stroke
Father	Y/N	_____	□ Alcoholism □ Arthritis □ Depression □ Cancer □ Diabetes □ Genetic disease □ Heart Disease □ Hypertension □ Osteoporosis □ Stroke
Mother	Y/N	_____	□ Alcoholism □ Arthritis □ Depression □ Cancer □ Diabetes □ Genetic disease □ Heart Disease □ Hypertension □ Osteoporosis □ Stroke
Brother/Sister	Y/N	_____	□ Alcoholism □ Arthritis □ Depression □ Cancer □ Diabetes □ Genetic disease □ Heart Disease □ Hypertension □ Osteoporosis □ Stroke
Brother/Sister	Y/N	_____	□ Alcoholism □ Arthritis □ Depression □ Cancer □ Diabetes □ Genetic disease □ Heart Disease □ Hypertension □ Osteoporosis □ Stroke
Other	Y/N	_____	□ Alcoholism □ Arthritis □ Depression □ Cancer □ Diabetes □ Genetic disease □ Heart Disease □ Hypertension □ Osteoporosis □ Stroke

SOCIAL HISTORY

Education
□ Less than 8th grade
□ High school
□ 2 year college
□ 4 year college
□ Post graduate

Marital Status
□ Married □ Single
□ Divorced □ Separated □ Widowed
□ Domestic partner

Exercise Level
□ None (no exercise)
□ Occasional exercise
□ Moderate exercise
□ High level exercise

Caffeine □ None □ Occasional
□ Moderate □ Heavy
# of cups/cans per day? _____

Alcohol Do you drink alcohol?
□ Yes □ No
If so, how often?
□ Occasionally □ < 3 times/wk
□ > 3 times/wk
How many drinks per week? _____

Tobacco Do you use tobacco?
□ Yes □ No

If not currently, did you ever use tobacco? □ Yes □ No
□ Cigarettes - _____ pks./day
□ Chew - _____/day
□ Cigars - _____/day
□ # of years _____
Or year quit _____

Drugs Do you currently use recreational or street drugs? □ Yes □ No
If yes, list:
_____
_____

REVIEW OF SYSTEMS

Please check all the apply:

Allergic/Immunologic
- □ Frequent Sneezing
- □ Hives
- □ Itching
- □ Runny Nose
- □ Sinus Pressure

Cardiovascular
- □ Arm Pain on Exertion
- □ Chest Pain on Exertion
- □ Chest Heaviness/Pressure on Exertion
- □ Irregular Heart Beats (Palpitations)
- □ Known Heart Murmur
- □ Light-headed on Standing
- □ Shortness of Breath When Lying Down
- □ Shortness of Breath When Walking
- □ Swelling (edema)

Constitutional
- □ Exercise Intolerance
- □ Fatigue
- □ Fever
- □ Weight Gain (_____lbs)
- □ Weight Loss (_____lbs)

Eyes
- □ Dry Eyes
- □ Irritation
- □ Vision Change

Date of Last Exam: _____

Ear/Nose/Mouth/Throat
- □ Bleeding Gums
- □ Difficulty Hearing
- □ Dry Mouth
- □ Ear Pain
- □ Frequent Infections
- □ Frequent Nosebleeds
- □ Hoarseness
- □ Mouth Breathing
- □ Mouth Ulcers
- □ Nose/Sinus Problems
- □ Ringing in Ears

Endocrine
- □ Fatigue
- □ Increased Thirst/Hunger/Urination

Gastrointestinal
- □ Abdominal Pain
- □ Black or Tarry Stool
- □ Blood in Stool
- □ Change in Appetite
- □ Frequent Indigestion
- □ Hemorrhoids
- □ Trouble Swallowing
- □ Vomiting
- □ Vomiting Blood

Genitourinary
- □ Blood in Urine
- □ Difficulty Urinating
- □ Incomplete Emptying
- □ Increased Urinary Frequency
- □ Urinary Loss of Control

Hematologic/Lymphatic
- □ Easy Bruising/Bleeding
- □ Swollen Glands

Integumentary (Skin)
- □ Change in Moles
- □ Dry Skin
- □ Eczema
- □ Growth/Lesions
- □ Itching
- □ Jaundice (Yellow Skin/Eyes)
- □ Rash

Musculoskeletal
- □ Back Pain
- □ Joint Pain
- □ Muscle Aches
- □ Muscle Weakness
- □ Wheezing

Neurological
- □ Dizziness
- □ Fainting
- □ Headaches
- □ Memory Loss
- □ Migraines
- □ Numbness
- □ Restless Legs
- □ Seizures

Psychiatric
- □ Alcohol Overuse
- □ Anxiety/Stress
- □ Do Not Feel Safe in Relationship
- □ Mania
- □ Sleep Problems

Respiratory
- □ Cough
- □ Coughing Up Blood
- □ Shortness of Breath
- □ Sleep Apnea
- □ Snoring

Please add any other information about your health that you would like your provider to know here:

_____ _____

Parent, Guardian, or Caregiver Signature Date

FAMILY MEDICINE AUSTIN

Diagnostic Based Healthcare.

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.

I understand that this authorization will remain in effect until I either submit a subsequent Patient Contact Authorization changing my above stated preferences, or I revoke this authorization in writing. To do so, I must send

written notice of revocation to Practice at 6633 US 290, Austin, TX; call Practice at (512) 872-6868; or utilize the opt-out or unsubscribe options included in any authorized text message or email contacts.

I acknowledge and agree that Practice, its employees, officers, and staff are released from any legal responsibility or liability for or resulting from the authorized disclosure of my health or billing information.

_____	_____
Printed Patient Name **Date**	**Signature of Patient**
_____	_____
Practice Representative Name Representative/Witness	**Signature of Practice**