

Family Health Center of Coppell

ALL ITEMS MUST BE COMPLETED
*****Please present a current Insurance card at each visit*****

PATIENT NAME _____ **DOB** _____
(last) (first) (middle)

Social Security# _____ **Sex** (please circle one) **M** **F**

Marital Status (please circle one) **S** **M** **W** **D** **Sep**

Patient Mailing Address _____
City _____ **State** _____ **Zip** _____
Phone: (H) _____ (W) _____ (Cell) _____

Patient Place of Employment _____

Full Name of Responsible Party (head of household) _____
Relationship to Patient _____
Responsible Party Address _____
City _____ **State** _____ **Zip** _____
Phone: (H) _____ (W) _____ (Cell) _____

If Patient is Married, Full Name of Spouse _____

Name of Primary Insurance Company _____
Effective Date _____ **Employer** _____
Policy Number _____ **Group #** _____
Insurance Address _____
Name of Insured Employee _____ **Relationship to Patient** _____
Insured Employee's SS # _____ **Insured's DOB** _____
Mailing Address of Insured (if different from Patient) _____
City _____ **State** _____ **Zip** _____
Phone: (H) _____ (W) _____ (Cell) _____

Name of Secondary Insurance, If Any _____
Effective Date _____ **Employer** _____
Policy Number _____ **Group #** _____
Insurance Address _____
Name of Insured Employee _____ **Relationship to Patient** _____
Insured Employee's SS # _____ **Insured's DOB** _____
Mailing Address of Insured (if different from Patient) _____
City _____ **State** _____ **Zip** _____
Phone: (H) _____ (W) _____ (Cell) _____

Who Can We Contact In Case of Emergency, Or if We Cannot Reach You?
(please complete Release of Information Section**)**

Name _____ **Relationship** _____
Phone: (H) _____ (W) _____ (Cell) _____

I verify the information above to be correct

***Patient Signature** _____ **Date** _____

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61 Family Health Center of Coppel DATABASE TOOL Medical and Personal History

Patient Name: _____ Date: _____
 DOB: _____ Sex: M / F Race: _____

For what reason are you here today? _____

Please check conditions which you have had?

GENERAL

- Serious Infections (e.g. pneumonia) _____
- Diabetes Mellitus
- Rheumatic Fever
- HIV Infection
- Cancer (where?) _____

CVS

- High Blood Pressure
- Congestive Heart Failure
- Heart Murmur
- Heart Valve Disease
- Angina
- Heart Attack
- High Cholesterol
- Abnormal Heart Rhythm
- Blood Clots in Veins
- Blocked Arteries in Neck
- Blocked Arteries in Legs

HEENT

- Glaucoma
- Allergies "hay fever"
- Frequent Ear Infections
- Frequent Sinus Infections

RESPIRATORY

- Asthma
- Emphysema
- Blood Clots in Lungs
- Sleep Apnea

MUSCULOSKELETAL / EXTREMITIES

- Osteoporosis
- Rheumatoid Arthritis
- Degenerative Joint Disease
- Fibromyalgia
- Neck Pain (herniated disc)
- Back Pain (herniated disc)

LYMPHATIC / HEMATOLOGIC

- Thyroid Goiter
- Over Active Thyroid
- Under Active Thyroid
- Transfusions
- Anemia

GI / GU

- Stomach Ulcers
- Ulcerative Colitis
- Crohns Disease
- Bleeding from Intestines
- Diverticulitis
- Colon Polyps
- Irritable Bowel Disease
- Hepatitis
- Cirrhosis of the Liver
- Liver Failure
- Pancreatitis
- Gallstones

Kidney Stones

- Kidney Failure
- Prostate Disease
- Endometriosis
- Sex Transmitted Infection

SKIN / BREAST

- Acne
- Eczema
- Psoriasis
- Fibrocystic Breast Disease

NEUROLOGIC / PSYCHIATRIC

- Chronic Vertigo (Meniere's)
- Peripheral Nerve Disease
- Migraine Headaches
- Stroke
- Multiple Sclerosis
- Depression
- Anxiety

Doctor's Notes: _____

Please indicate any surgeries you have had and the year you had them.

- | | | | |
|------------------------------|-----------------------------|-----------------------|----------------------|
| Year _____ | Year _____ | Year _____ | Year _____ |
| ____ Angioplasty | ____ Trauma Related Surgery | ____ Stomach Surgery | ____ Tubal Ligation |
| ____ Carotid Artery Surgery | ____ Back or Neck Surgery | ____ Inguinal Hernia | ____ C-Section |
| ____ Other Vascular Surgery | ____ Hip Surgery | ____ Colonoscopy | ____ Hysterectomy |
| ____ Coronary Bypass Surgery | ____ Knee Surgery | ____ Gallbladder | ____ Ovary Removed |
| ____ Chest / Lung Surgery | ____ Carpal Tunnel Surgery | ____ Appendectomy | ____ Breast Surgery |
| ____ Tonsillectomy | ____ Sinus Surgery | ____ Prostate Surgery | ____ Thyroid Surgery |
| ____ Neurosurgery | ____ Ear Surgery | ____ Bladder Surgery | ____ other _____ |

Doctor's Notes: _____

Please indicate when you last had any of the following preventative tests or services.

- | | | | |
|------------------------|------------------------|---------------------------------|---------------------------------|
| Year _____ | Year _____ | Year _____ | Year _____ |
| ____ Cardiac Angiogram | ____ Flu Vaccine | ____ Prostate Cancer Blood Test | ____ Mammogram / Breast Exam |
| ____ Stress Test | ____ Pneumonia Vaccine | ____ Rectal Exam | ____ Pap Smear |
| ____ Echocardiogram | ____ Tetanus Vaccine | ____ Colon Cancer Stool Test | ____ Date of Last Physical Exam |
| ____ Chest X-ray | ____ Hepatitis Vaccine | ____ Flexible Sigmoidoscopy | ____ other _____ |
| ____ EKG | ____ Bone Density Test | ____ Barium Enema | |

Doctor's Notes: _____

Please list any allergies or intolerance to drugs or other substances. _____

Please list the medications currently taken, their dosages, and how many times per day you take them.

FAMILY MEDICAL HISTORY

Please check or list any major illness in your family members. (Mother, Father, Brothers, Sisters, or Children)

<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Diabetes Mellitus	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Breast Cancer
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Ovarian Cancer
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Anemia	<input type="checkbox"/> Neurological Disorder	<input type="checkbox"/> Colon Cancer
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Prostate Cancer
<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> _____	<input type="checkbox"/> _____	<input type="checkbox"/> _____

Notes: _____

PERSONAL INFORMATION

Please write in or circle the information that applies to you:

Occupation: _____

Education	Sexuality	Marital Status	Living Status	Diet	Exercise	Alternative Medicine
primary	heterosexual	single	alone	none	none	holistic
secondary	homosexual	married	with spouse	low fat	walking	chiropractic
college	bisexual	divorced	with parents	low chol	aerobics	homeopathy
post grad	transsexual	widowed	assisted living	low carbo	weightlifting	acupuncture
doctorate		separated	nursing home	vegetarian	___ days / wk	herbal

Tobacco	Alcohol	Illicit Drugs	Caffeine
never / past / active	never / past / active	never / past / active	never / past / active
cigarette / cigar / pipe	liquor / wine / beer	cocaine / marijuana	coffee / tea / soda
snuff / dip / chewing	___ drinks per	heroin / amphetamine	___ cans / cups per day
Start _____ Stop _____	day / week / month	barbiturate / LSD / PCP	
packs per day _____	AA / Alcohol Rehab	IV Drug Abuse / Drug Rehab	

Doctor's Notes: _____

