East Texas Family Medicine
Now part of Catalyst Physician Group

**Please complete and return to the office prior to your appointment.** Today's Date: _____

Name: Last: _____, First: _____ MI: ___ Nickname: _____

Date of Birth: _____ Age: _____ Sex: M F SSN: _____

**Parent/Legal Guardian (if the patient is a minor):**

Name: Last: _____, First: _____ Relation: _____

Date of Birth: _____

Phone: Home: ( _____ ) _____ Work: ( _____ ) _____ Cell: ( _____ ) _____

Email: _____

**Please initial if it is alright to leave a detailed message with health information on your voicemail:** _____

Home Address:

_____
Street City State Zip

**If married, please provide the following spouse information:**

Name: _____ Date of Birth: _____

Address: ☐ Same as above or

_____
Street City State Zip

Emergency Contact: ☐ Same as parent/guardian or _____ Relation: _____

Phone: ( _____ ) _____ Alternative Phone: ( _____ ) _____

Address: ☐ Same as above or

_____
Street City State Zip

**Please list any persons you authorize the clinic to leave personal medical information with: (optional)**

Name: _____ Relation: _____

Name: _____ Relation: _____

**Primary Insurance:** _____ **Secondary Insurance:**_____

Subscriber Name: ☐ Self or _____ Subscriber Name: ☐ Self or _____

Subscriber Date of Birth: _____ Subscriber Date of Birth: _____

Subscriber SSN: _____ Subscriber SSN: _____

**Signature:** _____ **Date:** _____

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Patient Name: _____ DOB: _____ Today's Date: _____

**Past Medical History and Family History**

Last Annual Wellness Exam: _____

Most Important Concerns for this visit: 1. _____

2. _____

**ALLERGIES to Medication:** ☐ **Yes (detail below)** ☐ **No Known Drug Allergy**

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

**Other Allergies (please list):** _____

**MEDICATIONS: Please list all prescriptions and over-the-counter medications:**

**Prescriptions:**

| Medication | Dose | Instructions |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

(For additional items, please continues on back of this sheet)

**Over-the-Counter Medications (non prescription):**

| Medication | Dose | Instructions |
|---|---|---|
| | | |
| | | |

**Supplements:** Please list all herbal preparations and supplements that you take on a daily basis

| Description | Amount taken daily |
|---|---|
| | |
| | |

**Preferred Pharmacy**

Name: _____

Address: _____
Street City State Zip

Phone: (_____) _____

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**Do you have advanced directives?** (Living Will, Durable Power of Attorney for medical decisions) ☐ Yes ☐ No

**Please list other physicians and health care providers you see (specialists, therapists, counselors, chiropractors, etc):**

Provider_____ Reason _____
Provider_____ Reason _____
Provider_____ Reason _____
Provider_____ Reason _____

**PAST MEDICAL HISTORY:** Please describe any condition that you have yourself:

| **Condition (Check all that apply)** | **Details (Year of Diagnosis, etc)** |
|---|---|
| ☐ Eye Disease or Cataracts | _____ |
| ☐ Lung Disease | _____ |
| ☐ Heart Disease | _____ |
| ☐ Cancer | _____ |
| ☐ Depression/Anxiety | _____ |
| ☐ Mood Disorder | _____ |
| ☐ Diabetes | _____ |
| ☐ Digestive/stomach/GERD | _____ |
| ☐ Bleeding or Clotting Disorders | _____ |
| ☐ Hypertension | _____ |
| ☐ Elevated Cholesterol | _____ |
| ☐ Kidney Disease | _____ |
| ☐ Sleep Apnea | _____ |
| ☐ Thyroid Disease | _____ |
| ☐ Other: _____ | |

**Previous Surgeries**

| **Surgery** | **Details (Date, Complications, etc)** |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

**Other Hospitalizations (include year and reason for admission:**

_____

_____

Patient Name: _____ DOB: _____ Today's Date: _____

**FAMILY MEDICAL HISTORY:**

Father's Health Conditions: _____
Living? Y N If no, age of death _____
Mother's Health Conditions: _____
Living? Y N If no, age of death _____
Sibling's Health Conditions: _____
Other: _____
_____

**PERSONAL & SOCIAL HISTORY:**

**Do you smoke?**

- ☐ No, I have never smoked.
- ☐ Yes, I smoke ___ packs of cigarettes a day for ___ years.
- ☐ No, I quit smoking ___ years ago. I smoked ___ packs a day for ___ years.
- ☐ Yes, I smoke cigars or a pipe, ___ a day for ___ years.
- ☐ Yes, I use smokeless tobacco ___ times a day for ___ years.

Describe current dietary limitations: _____
Who lives with you? _____
Occupation (indicate if retired): _____
Foreign travel outside of the U.S. in the past year _____

Additional information you would like for us to know about your health:
_____
_____
_____
Previous Primary Care Physician: _____

**Please tell us if you have had any of the following screening tests, and the most recent date:**

Colonoscopy: _____

DEXA (bone density): _____

Women: Pap: _____ Mammogram: _____

**Adult Immunizations:**

| | | | | | | |
|---|---|---|---|---|---|---|
| Tetanus | ☐ Yes | ☐ No | Date:_____ | Was pertussis included (Tdap)? | ☐ Yes | ☐ No |
| Pneumonia | ☐ Yes | ☐ No | Date:_____ | | | |
| Hepatitis B | ☐ Yes | ☐ No | Dates (3 shots): _____ | | | |
| HPV | ☐ Yes | ☐ No | Dates (3 shots): _____ | | | |
| Zostavax | ☐ Yes | ☐ No | Date: _____ | | | |

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Patient Name: _____ DOB: _____ Today's Date: _____

**Review of Systems (Current health symptoms):**

| | | | |
|---|---|---|---|
| 1. | Have you had a recent **weight gain or loss** that worries you? | ☐ Yes | ☐ No |
| 2. | Have you had any **unexplained fevers or night sweats**? | ☐ Yes | ☐ No |
| 3. | Do you have **sinus or nasal allergy symptoms** that affect your quality of life? | ☐ Yes | ☐ No |
| 4. | Do you have any **vision or hearing problems** that are bothersome? | ☐ Yes | ☐ No |
| 5. | Are you experiencing **chest pains or irregular beats** that worry you? | ☐ Yes | ☐ No |
| 6. | Do you have unusual **shortness of breath or a persistent cough**? | ☐ Yes | ☐ No |
| 7. | Do you have **leg swelling** that is recurrent or bothersome? | ☐ Yes | ☐ No |
| 8. | Do you experience **wheezing** when you breathe? | ☐ Yes | ☐ No |
| 9. | Do you have **sleep problems** that interferes with your quality of life? | ☐ Yes | ☐ No |
| 10. | Have you been told that you **snore and stop breathing during sleep**? | ☐ Yes | ☐ No |
| 11. | Do you have **constipation, diarrhea, stomach pain**, or other problems with digestion that interfere with your quality of life? | ☐ Yes | ☐ No |
| 12. | Have your **bowel movement patterns** changed in the recent months? | ☐ Yes | ☐ No |
| 13. | Do you have **problems with urination** that affect your quality of life? | ☐ Yes | ☐ No |
| 14. | Do you have **joint or back problems** that affect your quality of life? | ☐ Yes | ☐ No |
| 15. | Do you have **leg pain, numbness, or weakness** that limits how fast or far you can walk? | ☐ Yes | ☐ No |
| 16. | Do you have **headaches** that affect your ability to function? | ☐ Yes | ☐ No |
| 17. | Have you had an **unexpected fall with injury** in the past year? | ☐ Yes | ☐ No |
| 18. | Do you have **little pleasure** in your daily activities? | ☐ Yes | ☐ No |
| 19. | Do you feel **depressed or hopeless**? | ☐ Yes | ☐ No |
| 20. | Are you concerned about **anxiety or stress** in your life? | ☐ Yes | ☐ No |
| 21. | Are you concerned about your **memory**? | ☐ Yes | ☐ No |

Comments: _____

_____

_____

**Note:** Evaluation of these concerns is not usually part of an annual wellness or preventative exam. It is likely that your doctor will need to schedule extra time or an additional appointment to follow up on these concerns.