PATIENT INFORMATION

PATIENT'S LAST NAME:	FIRST NAME:	MIDDLE:	MARITAL STATUS
			☐ ☐ ☐ ☐ ☐ SINGLE/ MAR/ DIV/ SEP/ WID

RACE:	SOCIAL SECURITY #:	BIRTH DATE:	SEX:
☐ DECLINED ☐ AMERICAN INDIAN/ ALASKA NATIVE ☐ ASIAN ☐ WHITE ☐ AFRICAN AMERICAN ☐ NATIVE HAWAIIAN ☐ OTHER			☐ MALE ☐ FEMALE

STREET ADDRESS:	BEST CONTACT NUMBER:

CITY:	STATE:	ZIP CODE:	EMAIL ADDRESS:

REFERRED TO CLINIC BY: (PLEASE CHECK ONE BOX)

☐ DR. ☐ INSURANCE PLAN ☐ HOSPITAL ☐ FAMILY/ FRIEND ☐ OTHER

PREFERRED PHARMACY METHOD:

LOCAL PHARMACY:_____

MAIL ORDER:_____

LIST YOUR PRESCRIBED DRUGS AND OVER-THE-COUNTER DRUGS, SUCH AS VITAMINS AND INHALERS

NAME THE DRUG	STRENGTH	FREQUENCY

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 CONFIDENTAL.				
EXERCISE	☐ SEDENTARY (NO EXERCISE)			
	☐ MILD EXERCISE (I.E, CLIMB STAIRS, WALKS 3 BLOCKS, GOLF)			
	☐ OCCASIONAL VIGOROUS EXERCISE (I.E, WORK OR RECREATION LESS THAN 4X/WEEK FOR 30 MINS.)			
	☐ REGULAR VIGOROUS EXERCISE (I.E, WORK OR RECREATION 4X/WEEK FOR 30 MINS.)			
DIET	ARE YOU DIETING?			☐ YES ☐ NO
	IF YES, ARE YOU ON A PHYSICAN PRESCRIBED MEDICAL DIET?			☐ YES ☐ NO
	# OF MEALS YOU EAT IN AN AVERAGE DAY?			
	RANK SALT INTAKE:			
	RANK FAT INTAKE:			
CAFFEINE (# OF EACH A DAY)	☐ NONE	☐ COFFEE	☐ TEA	☐ COLA
ALCOHOL	DO YOU DRINK?			☐ 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

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
FATHER			CHILDREN	☐M ☐F	
MOTHER				☐M ☐F	
SIBLINGS	☐M ☐F			☐M ☐F	
	☐M ☐F			☐M ☐F	
	☐M ☐F		GRANDMOTHER		
	☐M ☐F		GRANDFATHER		
	☐M ☐F		GRANDMOTHER		
	☐M ☐F		GRANDFATHER		

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 A PROBLEM WITH EATING OR 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 CAESAREAN?	☐YES	☐NO
ANY URINARY TRACT, BLADDER, OR KIDNEY INFECTIONS WITHIN THE LAST YEAR?	☐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
	___VAPING/ E-CIGARETTES- # OF MG NICOTINE/ BOTTLES A MONTH			
	___# OF YEARS		___OR YEARS 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 SAFTEY	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

PERMISSION TO RELEASE MEDICAL RECORDS

NAME: _____

DATE OF BIRTH:

FROM:	**TO**
	DR:
	ADDRESS:
	CITY/STATE:
	PHONE:
	FAX:

RELEASE RECORDS FOR THE FOLLOWING DATES OF SERVICE:

THE FOLLOWING INFORMATION IS REQUESTED AND MAY BE RELEASED:

☐ **ALL RECORDS** ☐ **OPERATIVE REPORTS** ☐ **MEDICATION INFORMATION**

☐ **MEDICAL SUMMARY** ☐ **EKG REPORTS** ☐ **X-RAY REPORTS**

☐ **PROGRESS NOTES** ☐ **LAB REPORTS** ☐ **OTHER**

I DO ☐ DO NOT ☐ CONSENT TO TRANSMISSION OF MY MEDICAL RECORDS VIA FAX MACHINE.

I RECOGNIZE THE INFORMATION DISCLOSED MAY CONTAIN MENTAL HEALTH INFORMATION THAT IS PROTECTED BY STATE AND FEDERAL LAWS.

I ☐ DO ☐ DO NOT CONSENT TO THE DISCLOSURE OF THIS INFORMATION.

SIGNATURE:_____DATE_____

I RECOGNIZE THE INFORMATION DISCLOSED MAY CONTAIN DRUG/ALCOHOL INFORMATION THAT IS PROTECTED BY STATE AND FEDERAL LAWS.

I ☐ DO ☐ DO NOT CONSENT TO THE DISCLOSURE OF THIS INFORMATION.

SIGNATURE:_____DATE_____

I RECOGNIZE THE INFORMATION DISCLOSED MAY CONTAIN INFORMATION REGARDING SEXUALLY TRANSMITTED DISEASES OR HIV/AIDS TESTING.

I ☐ DO ☐ DO NOT CONSENT TO THE DISCLOSURE OF THIS INFORMATION.

SIGNATURE:_____DATE_____

PERMISSION IS HEREBY GRANTED FOR RELEASE OF INFORMATION

SIGNATURE OF PATIENT OR REPRESENTATIVE: _____

RELATIONSHIP TO PATIENT: **DATE**

ARE YOU UNDER THE CARE OF A CARDIOLOGIST (HEART DOCTOR)? YES☐ NO☐

IF YOU MARKED YES WHAT IS THE DOCTORS NAME AND CONTACT INFORMATION

_____

ARE YOU ON ANY OF THE FOLLOWING MEDICATION? CIRCLE THOSE THAT APPLY:

☐ AGGRENOX	☐ COUMADIN/ WARFARIN	☐ INDOCIN	☐ PLETAL	☐ PRADAXA
☐ AGRYLIN	☐ DAYPRO	☐ KETOPROFEN	☐ XARELTO	☐ RELAFEN
☐ HEPARIN	☐ DICLOFENAC	☐ LODINE	☐ CELEBREX	☐ TRENTAL
☐ PLAVIX	☐ FELDENE	☐ LOVENOX	☐ PERSANTINE	☐ TICLID
☐ ARTHROTEC	☐ MOBIC			

NON PRESCRIPTION MEDICATIONS:

☐ ACTRON	☐ ALKA SELTZER	☐ FISH OIL	☐ NAPROXYN
☐ ASPIRIN PRODUCTS	☐ BC POWDER	☐ HALFPRIN	☐ NUPRIN
☐ ADVIL	☐ ECOTRIN	☐ IBUPROFEN	☐ ORUDIS
☐ ALEVE	☐ EXCEDRIN	☐ MOTRIN	☐ GINGKO BILOBA

DFW Physician Medical Associates

PATIENT HIPAA CONSENT FORM

I UNDERSTAND THAT I HAVE CERTAIN RIGHTS TO PRIVACY REGARDING MY PROTECTED HEALTH INFORMATION. THESE RIGHTS ARE GIVEN TO ME UNDER THE **HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA**). I UNDERSTAND THAT BY SIGNING THIS CONSENT I AUTHORIZE **DFWPMA** TO USE AND DISCLOSE MY PROTECTED HEALTH INFORMATION TO CARRY OUT:

- TREATMENT (INCLUDING DIRECT OR INDIRECT TREATMENT BY OTHER HEALTHCARE PROVIDERS INVOLVED IN MY TREATMENT).
- OBTAINING PAYMENT FROM THIRD PARTY PAYERS (E.G. MY INSURANCE COMPANY).
- THE DAY-TO-DAY HEALTHCARE OPERATIONS OF **DFWPMA.**

I HAVE ALSO BEEN INFORMED OF AND GIVEN THE RIGHT TO REVIEW AND SECURE A COPY OF THE CLINIC'S NOTICE OF PRIVACY PRACTICES, WHICH CONTAINS A MORE COMPLETE DESCRIPTION OF THE USES AND DISCLOSURES OF MY PROTECTED HEALTH INFORMATION AND MY RIGHTS UNDER **HIPAA**. I UNDERSTAND THAT **DFWPMA** RESERVES THE RIGHT TO CHANGE THE TERMS OF THIS NOTICE FROM TIME TO TIME AND THAT I MAY CONTACT THEM AT ANY TIME TO OBTAIN THE MOST CURRENT COPY OF THIS NOTICE.

I UNDERSTAND THAT I HAVE THE RIGHT TO REQUEST RESTRICTION ON HOW MY PROTECTED HEALTH INFORMATION IS USED AND DISCLOSED TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS, BUT **DFWPMA** IS NOT REQUIRED TO AGREE TO THESE REQUESTED RESTRICTIONS. HOWEVER, IF THEY DO AGREE, THEY ARE THEN BOUND TO COMPLY WITH THE RESTRICTION.

I UNDERSTAND THAT I MAY REVOKE THIS CONSENT, IN WRITING, AT ANY TIME. HOWEVER, ANY USE OR DISCLOSURE THAT OCCURRED PRIOR TO THE DATE I REVOKED THIS CONSENT IS NOT AFFECTED.

_____ _____

SIGNATURE OF PATIENT OR REPRESENTATIVE DATE

_____

PRINTED NAME

_____

RELATIONSHIP

OFFICE POLICIES

PATIENT NAME: _____

DATE OF BIRTH: _____

AS A PATIENT OF DFWPMA I UNDERSTAND THAT THE FOLLOWING POLICIES ARE CURRENTLY IN EFFECT:

- A $30.00 FEE WILL BE ASSESSED ON ALL RETURNED CHECKS. RETURNED CHECKS WILL BE PAID IN CASH WITHIN 10 DAYS OF NOTIFICATION. I ALSO UNDERSTAND IF OUTSTANDING CHECK IS NOT RESOLVED WITHIN THE 10 DAY LIMIT I MAY BE DISMISSED FROM THE PRACTICE.
- A $25.00 FEE MAY BE APPLIED TO MY ACCOUNT FOR ANY MISSED APPOINTMENTS I DO NOT CANCEL MORE THAN 24 HOURS IN ADVANCE. I ALSO UNDERSTAND THIS FEE, IF ASSESSED, MUST BE PAID PRIOR TO MY NEXT VISIT WITH DFWPMA.
- I UNDERSTAND PAYMENT IS DUE AT TIME SERVICES ARE RENDERED, UNLESS PRIOR PAYMENT ARRANGEMENTS ARE MADE WITH THE OFFICE. THIS INCLUDES ANY DEDUCTIBLE, COPAYMENT OR CO-INSURANCE AMOUNTS. ANY BALANCES NOT PAID BY MY INSURANCE CARRIER ARE MY RESPONSIBILLITY TO RESOLVE.
- **I UNDERSTAND IF I AM MORE THAN 15 MINS LATE FOR MY SCHEDULED APPOINTMENT I MAY BE ASKED TO RESCHEDULE FOR ANOTHER DAY.**
- **FINALLY, I UNDERSTAND THAT I AM TO ALLOW AT LEAST 48 HOURS FOR MY PRESCRIPTION REFILLS.**

MY SIGNATURE CONFIRMS I HAVE READ AND UNDERSTAND THE ABOVE OFFICE POLICIES AND HAVE HAD AN OPPORTUNITY TO ASK QUESTIONS REGARDING ANY CONCERNS I MAY HAVE ABOUT THESE POLICIES.

_____ _____

PATIENT SIGNATURE DATE

AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

(WHO DFWPMA CAN DISCUSS YOUR MEDICAL CARE WITH)

PATIENT NAME: _____

ADDRESS:_____

DATE OF BIRTH:_____SOCIAL SECURITY NUMBER:_____

AUTHORIZES DFW PHYSICIANS MEDICAL ASSOCIATES, TO RELEASE THE FOLLOWING MEDICAL INFORMATION TO:

NAME OF PERSON (FAMILY MEMBER. CAREGIVER, ETC.)

_____

ADDRESS:_____

CITY/ STATE/ZIP_____
PHONE NUMBER: _____

☐ CONFER ONLY WITH PERSON(S) LISTED BELOW ABOUT MY MEDICAL CONDITIONS: (FAMILY MEMBER, CAREGIVER, ETC.)

NAME OF PERSON:

_____

MAY WE CONTACT YOU AT THE NUMBER(S) LISTED IN PG.1 AND/OR LEAVE A MESSAGE? ☐YES ☐NO

MAY WE CONTACT YOU AT THE NUMBER(S) LISTED AND/OR LEAVE A MESSAGE REGARDING APPOINTMENTS? ☐YES ☐NO

THIS AUTHORIZATION SHALL BE VALID FROM THE DATE OF SIGNATURE. THE PATIENT CAN REVOKE THIS AUTHORIZATION AT ANY TIME.

THE PATIENT AGREES THAT A PHOTOCOPY OF THIS AUTHORIZATION MAY BE CONSIDERED VALID. ☐YES ☐NO

_____ _____

SIGNATURE OF PATIENT OR REPRESENTATIVE RELATIONSHIP TO PATIENT

_____ _____

DATE SIGNED WITNESS SIGNATURE

ALLERGY HISTORY

PATIENT NAME:_____ DATE:_____

BRANSON ALLERGY SYMPTOM EVALUATION (BASE)

COMPLAINTS PLEASE CIRCLE THE APPROPRIATE NUMBER 0 TO 3 ACCORDING TO SEVERITY

0 = ABSENT (NO SYMPTOMS EVIDENT) **2 = MODERATE** (TOLERABLE)

1 = MILD (SYMPTOMS PRESENT, BUT MINIMAL AWARENESS) **3 = SEVERE**

NASAL DISCHARGE (RUNNY NOSE)	0 1 2 3	HEADACHE	0 1 2 3
NASAL OBSTRUCTION (STUFFY NOSE)	0 1 2 3	HIVES	0 1 2 3
NASAL ITCHING	0 1 2 3	ECZEMA	0 1 2 3
SNEEZING	0 1 2 3	ITCHING EARS	0 1 2 3
WATERY EYES	0 1 2 3	SINUS OR EAR INFECTIONS	0 1 2 3
ITCHY EYES	0 1 2 3	FREQUENT COLDS OR SORE THROAT	0 1 2 3
GRITTY FEELING (EYES)	0 1 2 3	SENSITIVITY TO PET HAIR	0 1 2 3
COUGH	0 1 2 3	ITCHY THROAT	0 1 2 3
WHEEZING	0 1 2 3	SINUS PRESSURE	0 1 2 3
DIFFICULTY BREATHING	0 1 2 3	SINUS PAIN	0 1 2 3

OTHER SYMPTOMS CAUSING YOU PROBLEMS?

_____

MEDICATIONS:

HOW OFTEN DO YOU TAKE MEDICATIONS FOR YOUR ALLERGY SYMPTOMS?

0 = NEVER 1 = OCCASIONALLY (SEVERAL TIMES A MONTH OR LESS) **2 = FREQUENTLY** (SEVERAL TIMES A WEEK) **3 = DAILY**

ANTIHISTAMINES	0 1 2 3	NASAL STEROIDS (FLONASE, NASACORT)	0 1 2 3
ORAL STEROIDS	0 1 2 3	ASTHMA MEDICATION (INHALER, SINGULAR, ADVAIR)	0 1 2 3
EYE DROPS	0 1 2 3	OTHER ALLERGY-RELATED MEDICATIONS_____	

DOES ANY MEDICATION GIVE YOU COMPLETE RELIEF OF SYMPTOMS?_____

GENERAL ALLERGY HISTORY:

HOW MANY MONTHS OF THE YEAR DO YOU HAVE ALLERGIES? _____ HOW MANY YEARS? _____

IN WHAT SEASON ARE THEY WORSE (CHECK ALL THAT APPLY): ☐ SPRING ☐ SUMMER ☐ FALL ☐ WINTER

HAVE YOU BEEN ALLERGY TESTED BEFORE? ☐ YES ☐ NO

IF YES, WHICH TYPE: ☐ SKIN PRICK/PUNCTURE ☐ BLOOD DRAW

HAVE YOU PREVIOUSLY RECEIVED ALLERGY SHOTS?_____ALLERGY DROPS?_____IF YES,WHEN?_____

LIST ANY ANIMALS YOU HAVE IN OR AROUND THE HOME_____

WHO ELSE IN YOUR FAMILY HAS ALLERGIES?_____

PROVIDER ONLY

RAW SCORE: _____ /25 0-25 = MILD 25-50 = SIGNIFICANT

SCORE: _____ (MULTIPLY RAW SCORE BY 4) 51-100 = SEVERE 100+ = VERY SEVERE

Health History Questionnaire

Name	M/F	Date of Birth

Marital States	Single ☐	Married ☐	Separated ☐	Divorced ☐	Other ☐
Previous or referring Doctor			Date of last physical exam		
Personal Health History					
Childhood Illness		Measles ☐	Mumps ☐	Rubella ☐	Chickenpox ☐
		Rheumatic Fever ☐	Polio ☐		
Immunizations and dates		Tetanus ☐		Pneumonia ☐	
		Hepatitis ☐		Chickenpox ☐	
		Influenza ☐		MMR ☐	

Surgeries

Years	Reason	Hospital

Other Hospitalizations

Years	Reason	Hospital

Have you ever had a blood transfusion? If yes, when? How many?	☐ Yes	☐ No