Family Medicine Clinic & Medical Weight Loss Clinic

813 South Amy Lane
Ste 101
Harker Heights, TX, 76548
Phone: 254-699-8521

Today's Date:

Reason for Visit:

PATIENT INFORMATION

Full Name:		Birth Date:
Social Security Number:	☐ M ☐ F	Marital Status:

Address:

Race: ☐ African-American ☐ American Indian/Alaskan Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ White

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino Language: ☐ English ☐ Spanish ☐ Other

COMMUNICATION PREFERENCES

Home Phone:	Cell Phone:	Work Phone:

Email Address: *(for statements and patient portal)*

How Would You Like to Receive Appointment Reminders?	May we leave detailed voicemails?
☐ Home Phone Call ☐ Cell Phone Call ☐ Work Phone Call ☐ Text Message ☐ Email	☐ Yes ☐ No

EMERGENCY CONTACT

Name:	Relationship to Patient:	
Primary Phone:	Secondary Phone:	☐ You can speak with this person in detail about my healthcare.

Names of other individuals that FPE may speak to about my healthcare:

INSURANCE

YOU MUST SUBMIT PHOTO COPIES OF THESE CARDS (FRONT & BACK) WITH YOUR PACKET

Primary Insurance:	ID#:
Secondary Insurance:	ID#:

GUARANTOR INFORMATION

Name:	Relationship to Patient:
Address:	Date of Birth:
	Phone:

By signing below, I am acknowledging the following:

- I have reviewed the information above for correctness and have made any and all changes necessary.
- I hereby authorize and consent to examinations, treatments, and release of medical information to insurance companies, claim representatives, adjusters, and other physicians necessary to process claims and assign to the physician payment for services.
- A copy of the Notice of Privacy Practices for Family Physicians of Evans has been made available to me on the website and in the office. I have been provided with an opportunity to ask questions regarding the Notice and its contents.

Patient/Guardian signature Date

Patient Health History Questionnaire

PATIENT INFORMATION

Full Name:	Birth Date:	Today's Date:

REASON FOR VISIT

ALLERGIES

Type	Reaction
i.e. Latex	*Rash*

PAST HOSPITALIZATIONS/SURGERIES

Description	Date

CURRENT MEDICATIONS

You must list ALL of your medications that you take regularly.
If you do not provide a complete medication list here, we may decline to establish a physician-patient relationship.

NAME	DOSAGE	FREQUENCY	REASON
i.e. Advil	*200mg*	*2 tablets once a day*	*Back pain*

PREFERRED PHARMACIES

	Name	Location	Phone
Local			
Mail Order			

CURRENT MEDICAL PROBLEMS

☐ Anxiety	☐ Depression	☐ Diabetes	☐ Heart Problems
☐ High Blood Pressure	☐ High Cholesterol	☐ Lung Problems	☐ Thyroid Problems

☐ Other:

SPECIALISTS/OTHER HEALTHCARE PROVIDERS

Previous Primary Care -	OB/GYN -
Cardiology -	Urology -
Dermatology -	Oncology -
Endocrinology -	Ophthalmology -
Other Providers -	

HEALTH MAINTENANCE

When was your last...	Date	Provider/Location	Results
Colonoscopy			
Pap Smear			
Mammogram			
PSA (Prostate Screen)			
DEXA (Bone Density Test)			
Eye Exam			
Pneumonia Shot			
- Pneumovax			
- Prevnar			
Flu Shot			
Shingles Shot			
Tetanus Shot			

FAMILY HISTORY

Do you have a family history of...		Who?	Do you have a family history of...		Who?
Breast Cancer	☐ Y ☐ N		Colon Cancer	☐ Y ☐ N	
High Cholesterol	☐ Y ☐ N		Prostate Cancer	☐ Y ☐ N	
Diabetes	☐ Y ☐ N		Osteoporosis	☐ Y ☐ N	
Heart Attack	☐ Y ☐ N		Anxiety/Depression	☐ Y ☐ N	
Heart Problems	☐ Y ☐ N		Psych/drug/alcohol problems	☐ Y ☐ N	
Stroke	☐ Y ☐ N		High Blood Pressure	☐ Y ☐ N	

SOCIAL HISTORY

Do you currently use tobacco or nicotine? ☐ No, Never ☐ Yes, Cigarettes ☐ Yes, Cigars
☐ No, Former Smoker ☐ Yes, Smokeless Tobacco ☐ Yes, E-Cig/Vape

If you do use tobacco, how often/how much do you use? ☐ I am interested in quitting.

Do you drink alcohol? ☐ No ☐ Yes – How Much/Often?

Do you currently exercise? ☐ No ☐ Yes – Type of Exercise? How Often?

What is your marital status? ☐ Single ☐ Divorced ☐ Widowed ☐ Separated ☐ Married ☐ Engaged

Who lives with you in your home?

Do you have children? ☐ No ☐ Yes – What are their names and ages?

Are you employed? ☐ No ☐ Retired ☐ Yes - Where?

Do you attend religious services? ☐ No ☐ Yes - Where?

What are your hobbies?

How did you hear about our practice?

Do we currently see any of your family members? If so, what are their names?

Patient Name (Printed) Date of Birth