CAPITAL MEDICAL CLINIC
PATIENT INFORMATION

Last Name:_____ **First Name:**_____ **Middle Initial:**_____

Address:_____**Apt#:**_____**City:**_____**State:**_____**Zip:**_____

Home#:_____ **Work#:**_____ **Cell#:**_____

Age:_____ **Sex:** **M** **F** **Date of Birth:**_____ **Marital Status:**_____**SS#:**_____

Employer's Name: _____ **Occupation:**_____

Address: _____ **City:**_____ **Zip:**_____

Spouse Name:_____**Home#**_____**Work#**_____

Emergency Contact:_____**Relationship:**_____**Phone#:**_____

Who referred you? **(please circle)** **FAMILY** **FRIEND** **PHYSICIAN REFERRAL** **ADVERTISEMENT** **WEBSITE**

INSURANCE INFORMATION OF POLICY HOLDER

Primary Insurance:_____**Address:**_____**State/Zip:**_____**Phone#:**_____

ID#:_____ **Group#:**_____ **Policy Holder Employer:**_____

Policy Holder: _____**Date of Birth:**_____ **SS#:**_____**Relationship:**_____

Secondary Insurance:_____**Address:**_____**State/Zip:**_____**Phone#:**_____

ID#:_____ **Group#:**_____ **Policy Holder Employer:**_____

Policy Holder:_____**Date of Birth:**_____ **SS#:**_____**Relationship:**_____

Patient Consent to Share Personal Health Information

I hereby authorize Capital Medical Clinic to share my personal health information with named persons below until further written notice from me:

Name:_____ **Relationship to Patient:**_____

Name:_____ **Relationship to Patient:**_____

Name:_____ **Relationship to Patient:**_____

Assignment and Authorization of Benefits

I hereby give authorization for payment of insurance benefits to be made directly to Capital Medical Clinic, LLP for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection and reasonable attorney fees. I hereby authorize this healthcare provider to release all information necessary to secure payment of benefits. I further agree that a photocopy of this Agreement is as valid as the original.

Acknowledgement of Review of Notice of Privacy Practices

I have been given the opportunity to review this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Authorization for Voicemail Usage for PHI

I hereby give permission to leave a message on my voicemail concerning my personal health information ☐ **(decline option)**

Capital Medical Clinic reserves the right to charge $50.00 for any appointment cancelled without 24hr-advanced notice and there is a $25.00 charge to your account for each returned check.

Signature: **Date:** **Witness:** **Date:**

CapitalMedicalClinic

Serving Austin since 1934

New Patient Evaluation

Name: _____ Date of Exam: _____

Referred by: _____ Date of Birth: _____

Reason for your visit:

Please list your chief complaints or concerns:
(*Please limit these to 2-3 per visit so that we can provide adequate attention to each issue*.)

1. _____

2. _____

3. _____

Specialists

Name of Specialist	Type of Specialty

Past Medical History:

1. Medications (All medications you are currently taking, including over the counter)

Name	Dosage (Milligrams)	Times per day
a.		
b.		
c.		
d.		

e. _____

f. _____

g. _____

2. Medication Allergies

Medication:	Reaction:
a. _____	
b. _____	
c. _____	

3. Operations

Operations	Date of Operations:
a. _____	
b. _____	
c. _____	
d. _____	
e. _____	
f. _____	

4. Please list all previous illnesses (e.g. diabetes, hypertension, hospitalizations)

Illness	Date of Diagnosis
a. _____	
b. _____	
c. _____	
d. _____	
e. _____	
f. _____	
g. _____	

h. _____

i. _____

j. _____

Family History

	Circle	Illnesses	Age at Illness Diagnosis
Mother	Living/Deceased (Age___)	a. _____	
		b. _____	
		c. _____	
Father	Living/Deceased (Age___)	a. _____	
		b. _____	
		c. _____	
Sibling Sister/Brother	Living/Deceased (Age___)	a. _____	
		b. _____	
Sibling Sister/Brother	Living/Deceased (Age___)	a. _____	
		b. _____	
Sibling Sister/Brother	Living/Deceased (Age___)	a. _____	
		b. _____	

Social History

1. Spousal Status (Please circle): Married Partnered Single Widowed

2. Living Arrangement (Please circle): Live alone Live with other(s)
Live with whom?_____

3. Children: Yes/No Number of Children Ages of Children

_____

4. Occupation: _____

5. Exercise: # of days per week How long per session? Type of Exercise

_____

6. Hobbies (How do you spend your free time?)

_____

7. Do you smoke tobacco now? Yes or No Packs/Day # of Years

_____

Have you ever smoked tobacco? Yes or No _____

What year did you quit smoking tobacco? _____

8. Do you drink alcohol? Yes or No Beverages per day per week

_____

9. Have you ever used recreational drugs? Yes or No

If yes, which drugs?_____

10. Have you recently traveled out of the country? Yes or No

If yes, where?_____

Review of Systems:

Please circle if you have had recently had problems with any of the following:

General:

Weight Gain (How much? _____ Over how long? _____)
Weight Loss (How much? _____ Over how long? _____)
Fatigue Fever Night sweats Heat or cold intolerance

Skin

Rash Hair loss Easy bruising Toenail infection

Eyes

Redness Pain Discharge Dryness Visual changes

Nose

Nose bleed Nasal discharge/drainage Sinus pain Sinus congestion

Mouth
Oral lesions White patches Bleeding gums Toothache

Throat
Hoarseness Sore Throat Pain with swallowing Difficulty swallowing

Respiratory
Cough Coughing blood Shortness of breath at rest
Shortness of breath on exertion Wheezing

Cardiovascular
Chest discomfort Palpitations (Heart fluttering or racing)
Ankle swelling Fast heart beat
Difficulty breathing when lying down Awakening short of breath

Urinary
Pain with urination Urinating frequently
Incontinence (losing your urine) with coughing/laughing
Urinating before you can get to the bathroom
Urination at night Difficulty starting a urine stream Blood in urine

Gastrointestinal
Nausea/Vomiting Diarrhea Blood in the stool
Black, tarry stool Heartburn/Reflux Constipation

Sexual
Difficulty achieving and maintaining an erection Decreased libido

Musculoskeletal
Joint pain or stiffness: Which joints? _____
Joint swelling or redness Which joints? _____
Back pain Muscle pain

Neurological
Difficulty with memory Fainting/Losing consciousness
☐ Weakness: Which part of your body? _____
Seizures Severe or frequent headaches Difficulty with balance
Difficulty walking Lightheadedness Vertigo (world spinning around you)

Psychological
Depression
Lack of interest in and enjoyment of activities that used to bring pleasure/fulfillment
Decreased sense of self-worth Difficulty focusing and concentrating
Desire to end your life Disabling anxiety Panic attacks

Sleep

Difficulty getting to sleep Difficulty staying asleep

Snoring Cessation of breathing during sleep (as reported by bed partner)

Health Maintenance/Yearly Physical Sheet Date _____

Cholesterol

Most recent cholesterol Date Total Cholesterol LDL HDL Triglycerides

_____

Vaccines

When did you last receive a Tetanus vaccine booster? _____

Have you received the Shingles vaccine? Yes or No or Not sure

Have you received the Pneumovax (pneumonia vaccine)? Yes or No or Not sure If yes, when?_____

Have you received the Flu Vaccine this flu season? ☐ Yes or No

Colon Cancer Screening

Have you had a colonoscopy? _____

If have had a colonoscopy, when did you last have it done? _____

Was your colonoscopy normal? _____

If it was abnormal, what was found? _____

Bone density

Have you had a bone density test? Yes or No or Not Sure

If yes, when did you last have it done? _____

For women:

When was your last mammogram? _____

Have you had a hysterectomy? Yes or No When? Why?

_____

When was your last pap smear? _____

Have you ever had an abnormal pap smear? Yes or No When?_____

For men:

When did you have your last digital rectal exam and PSA checked? _____

Skin

Have you had a skin cancer screening check by a dermatologist? Yes or No When?_____