

Austin Adult Primary Care



(Please Print)

Today's date:		PCP:	
PATIENT INFORMATION			
Patient's last name:		First:	Middle:
		<input type="checkbox"/> Mr.	<input type="checkbox"/> Miss
		<input type="checkbox"/> Mrs.	<input type="checkbox"/> Ms.
Marital status			
Single Mar Div Sep Wid			
Is this your legal name?	If not, what is your legal name?	Social Security #	Birth date:
<input type="checkbox"/> Yes <input type="checkbox"/> No			/ /
		Age:	Sex:
			<input type="checkbox"/> M <input type="checkbox"/> F
Street address:		Home Phone #	Cellular #
P.O. Box:		()	()
City:	State:	Zip Code:	Email Address:
Occupation:	Employer:	Employer phone no.:	
		()	
Chose clinic because/Referred to clinic by (please check one box):		<input type="checkbox"/> Dr.	<input type="checkbox"/> Insurance Plan
		<input type="checkbox"/> Hospital	
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages
<input type="checkbox"/> Other			
Other family members seen here:			

Preferred Pharmacy (Please include name & address):

- Local Pharmacy : _____
- Mail Order: _____

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone #	Work phone #
<p>The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Austin Adult Primary Care or insurance company to release any information required to process my claims.</p>			
<p>_____</p> <p><i>Patient/Guardian signature</i></p>		<p>_____</p> <p><i>Date</i></p>	

ORIGINAL DATE:

DATES REVISED:

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

NAME (Last, First, M.I.):		<input type="checkbox"/> M <input type="checkbox"/> F	DOB:
MARITAL STATUS: <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			
PREVIOUS OR REFERRING DOCTOR:		DATE OF LAST PHYSICAL EXAM:	

PERSONAL HEALTH HISTORY

CHILDHOOD ILLNESS: <input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rubella <input type="checkbox"/> Chickenpox <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Polio		
Immunizations and dates:	<input type="checkbox"/> Tetanus	<input type="checkbox"/> Pneumonia
	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Chickenpox
	<input type="checkbox"/> Influenza	<input type="checkbox"/> MMR <i>Measles, Mumps, Rubella</i>

LIST ANY MEDICAL PROBLEMS THAT OTHER DOCTORS HAVE DIAGNOSED

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SURGERIES

Year	Reason	Hospital

OTHER HOSPITALIZATIONS

Year	Reason	Hospital

HAVE YOU EVER HAD A BLOOD TRANSFUSION? IF YES , WHEN? :	How many?:	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Please turn to next page

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

Name the Drug	Strength	Frequency Taken

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 CONFIDENTIAL.

Exercise	<input type="checkbox"/> Sedentary (No exercise)		
	<input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf)		
	<input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)		
	<input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)		
Diet	Are you dieting?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, are you on a physician prescribed medical diet?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	# of meals you eat in an average day?		
	Rank salt intake	<input type="checkbox"/> Hi <input type="checkbox"/> Med <input type="checkbox"/> Low	
	Rank fat intake	<input type="checkbox"/> Hi <input type="checkbox"/> Med <input type="checkbox"/> Low	
Caffeine	<input type="checkbox"/> None <input type="checkbox"/> Coffee <input type="checkbox"/> Tea <input type="checkbox"/> Cola		
	# of cups/cans per day?		
Alcohol	Do you drink alcohol?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, what kind?		
	How many drinks per week?		
	Are you concerned about the amount you drink?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you considered stopping?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever experienced blackouts?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Are you prone to "binge" drinking?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you drive after drinking?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Tobacco	Do you use tobacco?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes – pks./day	<input type="checkbox"/> Chew - #/day	<input type="checkbox"/> Pipe - #/day <input type="checkbox"/> Cigars - #/day
	<input type="checkbox"/> # of years	<input type="checkbox"/> Or year quit	

Drugs	Do you currently use recreational or street drugs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have you ever given yourself street drugs with a needle?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sex	Are you sexually active?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, are you trying for a pregnancy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If not trying for a pregnancy list contraceptive or barrier method used:		
	Any discomfort with intercourse?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Personal Safety	Do you live alone?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have frequent falls?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have vision or hearing loss?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you have an Advance Directive or Living Will?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Would you like information on the preparation of these?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
FATHER			Children	<input type="checkbox"/> M <input type="checkbox"/> F	
MOTHER				<input type="checkbox"/> M <input type="checkbox"/> F	
Sibling	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> M <input type="checkbox"/> F	
	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F		GRANDMOTHER <i>Maternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		GRANDFATHER <i>Maternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		GRANDMOTHER <i>Paternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		GRANDFATHER <i>Paternal</i>		

MENTAL HEALTH

Is stress a major problem for you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel depressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you panic when stressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have problems with eating or your appetite?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you cry frequently?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever attempted suicide?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever seriously thought about hurting yourself?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have trouble sleeping?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been to a counselor?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

WOMEN ONLY

Age at onset of menstruation:		
Date of last menstruation:		
Period every ____ days		
Heavy periods, irregularity, spotting, pain, or discharge?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Number of pregnancies ____ Number of live births ____		
Are you pregnant or breastfeeding?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had a D&C, hysterectomy, or Cesarean?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any urinary tract, bladder, or kidney infections within the last year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any blood in your urine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any problems with control of urination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any hot flashes or sweating at night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Experienced any recent breast tenderness, lumps, or nipple discharge?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Date of last pap and rectal exam?		

MEN ONLY

Do you usually get up to urinate during the night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, # of times ____		
Do you feel pain or burning with urination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any blood in your urine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel burning discharge from penis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has the force of your urination decreased?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any problems emptying your bladder completely?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any difficulty with erection or ejaculation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any testicle pain or swelling?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Date of last prostate and rectal exam?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

<input type="checkbox"/> Skin	<input type="checkbox"/> Chest/Heart	<input type="checkbox"/> Recent changes in:
<input type="checkbox"/> Head/Neck	<input type="checkbox"/> Back	<input type="checkbox"/> Weight
<input type="checkbox"/> Ears	<input type="checkbox"/> Intestinal	<input type="checkbox"/> Energy level
<input type="checkbox"/> Nose	<input type="checkbox"/> Bladder	<input type="checkbox"/> Ability to sleep
<input type="checkbox"/> Throat	<input type="checkbox"/> Bowel	<input type="checkbox"/> Other pain/discomfort:
<input type="checkbox"/> Lungs	<input type="checkbox"/> Circulation	

**AUSTIN ADULT PRIMARY CARE
5301 W. DUVAL RD. SUITE A-500
AUSTIN, TX 78727
Ph: (512) 222-0000 Fax: (512) 222-0019**

PERMISSION TO RELEASE MEDICAL RECORDS

Name: _____ Date of Birth: _____

Social Security #: _____

PLEASE RELEASE MY RECORDS:

From: _____

(Doctor's Name)

To:

**Austin Adult Primary Care
5301 W. Duval Rd. Suite A-500
Austin, TX 78727**

(City/State/Zip)

Release records for the following dates of service: From: _____

The purpose of this release is: _____

The following information is requested and may be released:

- All Records** Medical Summary Progress Notes Operative Reports EKG Reports
 Lab Reports Medical Information X-Ray Reports Other _____

PERMISSION IS HEREBY GRANTED FOR RELEASE OF INFORMATION

Signature of Patient or Representative

Relationship to Patient

Date Signed

Witness Signature

*******REQUIRED**

I do do not consent to transmission of my medical records via fax machine.

Signature

Date

OPTIONAL

I recognize the information disclosed may contain mental health information that is protected by state and federal laws. I consent to the disclosure of this information.

Signature

Date

I recognize the information released may contain drug/alcohol information that is protected by federal and state law. I consent to disclosure of such information.

Signature

Date

I recognize the information disclosed may contain information regarding sexually transmitted diseases or HIV/Aids testing. I consent to disclosure of this information.

Signature

Date

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5301 W. DUVAL RD. SUITE A-500
AUSTIN, TX 78727
Ph: (512) 222-0000 Fax: (512) 222-0019**

AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

PatientName: _____

Address: _____

Date of Birth: _____ Social Security Number: _____

Authorizes ***Austin Adult Primary Care***, to release the following medical information to:

Name of Person (family member, caregiver, etc.) _____

Address: _____

City/State/Zip _____ Phone Number: _____

Confer orally with person(s) listed below about my medical conditions: (family member, caregiver, etc.)

Name of Person: _____

May we contact you at work and/or leave a message? Yes No

May we contact you at home 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 in writing at any time.

The patient agrees that photocopy of this authorization may be considered valid. Yes No

Signature of Patient or Representative

Relationship to Patient

Date Signed

Witness Signature



Austin Adult Primary Care

Office Policies

Patient Name: _____ **Date of birth:** _____

As a patient of Austin adult Primary Care I understand that the following policies are currently in effect:

- A \$30.00 fee will be assessed on all returned checks. Returned checks will have to 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 will be applied to my account for any missed appointments I do not cancel more than 24 hours in advance. *I also understand this fee must be paid prior to my next visit with Austin adult Primary Care, no exceptions.*
- I understand payment is due at time services are rendered, unless prior payment arrangements are made with office. This includes any deductible, copayment or co-insurance amounts. Any balances not paid by my insurance carrier are my responsibility to resolve. I further understand that balances due must be paid in a timely manner to avoid further collection action. I understand if my account is forwarded to a collection agency I will be dismissed from the practice, my outstanding balance will be reported to the credit bureau and my balance will be charged a 25% interest rate per year until balance is resolved.
- I am to present proof of my insurance coverage at every office visit.
- **I understand if I am more than 15 minutes late for my scheduled appointment I may be asked to reschedule for another day.**
- Finally, I understand that I am to allow **at least 7-10 business days** for my prescription refills.

My signature confirms I have read & understood the above office policies and have had an opportunity to ask questions regarding any concerns I may have about these policies.

Patient Signature

Date