Woodlands Internists , P.A

150 Pine Forest Drive Suite 703 Shenandoah, TX 77384 Tele #: 936-270-8594

Date:
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PATIENT INFORMATION & HEALTH QUESTIONNAIRE

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

Name	☐ M ☐ F	**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		
Previous or referring doctor:	**Date of last physical exam:**	

Primary Phone #: **Alternate Phone #:**
Email:
Physical Address:
Mailing Address:
Social Security #: **Drivers Lic #:**
Occupation: **Employer:** **Employer Phone #:**
Emergency contact name: **Phone #**

Insurance Information

Primary Insurance Name:

Policy ID #: Group #:

Policy holder: Social Security#: DOB:

Secondary Insurance Name:

Policy ID #: Group #:

Policy holder: Social Security #: DOB:

PERSONAL HEALTH HISTORY

Childhood illness:	☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio	
Immunizations and dates:	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Chickenpox
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella*

List any medical problems that other doctors have diagnosed

Surgeries		
Year	Reason	Hospital
Other hospitalizations		
Year	Reason	Hospital

Have you ever had a blood transfusion?	☐ Yes	☐ No

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	

Local Pharmacy : **Phone #:**

Mail Order Pharmacy: **Phone #:**

Member ID #:

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.					
Exercise	☐ Sedentary (No exercise)				
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)				
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)				
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)				
	☐ Do you have any chest pain, dizziness, and palpitations during exercise or after exercise?				
Diet	Are you dieting?			☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?			☐ Yes	☐ No
	# of meals you eat in an average day?				
	Rank salt intake	☐ Hi	☐ Med	☐ Low	
	Rank fat intake	☐ Hi	☐ Med	☐ Low	
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola	
	# of cups/cans per day?				
Alcohol	Do you drink alcohol?			☐ 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
	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	
	☐ # of years	☐ Or year 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
Sleep	Please indicate how likely you would be to doze off or fall asleep in the following situations? Sitting and reading? Never (0) Slight (1) Moderate (2) High (3) Watching TV? Never (0) Slight (1) Moderate (2) High (3) Sitting inactive in a meeting, seminar or theatre, ect? Never (0) Slight (1) Moderate (2) High (3) As a passenger in a car for one hour? Never (0) Slight (1) Moderate (2) High (3) Lying down to rest in the afternoon? Never (0) Slight (1) Moderate (2) High (3) While having a relaxed conversation? Never (0) Slight (1) Moderate (2) High (3) Sitting quietly after lunch? Never (0) Slight (1) Moderate (2) High (3)			Total	#:
Personal Safety	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 and/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

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

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 Cesarean?	☐ Yes	☐ No
Date of last pap & rectal exam?		
Date of last pap and rectal exam?		
Date of your last bone density test?		

MEN ONLY

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

Date of your last bone density?

Any other concerns?

OTHER PROBLEMS

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

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	Dizziness or Giddiness?
Syncope / Collapse?	Vertigo?	Anxiety?
Depression?	Migraines?	ADD/ADHD?
Asthma?		
Do you have a pacemaker?	Do you have low blood pressure?	Have you had laser eye surgery within 90days?
Do you have a defibrillator?	Are you taking 3 or more medications?	Are you getting the full benefit from your medications?
Do you have any upcoming procedures?		

POLICIES

Thank You for choosing Woodlands Internists, P.A. as your healthcare provider. We are committed to taking care of every aspect of your health. Your clear understanding of our policies is important to our professional relationship. We ask that you carefully read and initial each statement, then please sign at the bottom.
We require a copy of all insurance cards and ask that you present those at each visit along with your driver's license or photo ID.

INSURANCE:_____
The patient is responsible for knowing their insurance benefits and if you have a deductible or copayment. If you have an HMO policy YOU MUST change your PCP to one of our providers before your visit. We will gladly file your insurance claims on your behalf. We will not become involved in disputes between you and your insurance regarding coverage and/or policy benefits. **PAYMENT IS DUE AT TIME OF SERVICE. Any balances on your account are due prior to being seen by our providers.**

RETURNED CHECKS: ____
There will be a $35 service fee on all dishonored checks. If payment is not received with full amount of check plus service fee within 10 days your information will be filed with The Montgomery County Hot Check Division. If you have any occurrences we will no longer be able to accept checks from you.

APPOINTMENTS: _____
When a patient arrives late it is important to stay on schedule. If you arrive more than 15 minutes late you may be asked to reschedule24hrs in advance. For diagnostic testing and procedures, a fee of $50 will be added to your account unless we have been notified 24 hrs in advance.

PRESCRIPTIONS: _____
Refills: It is the patient's responsibility to contact their pharmacy 5 days prior to running out of medications. Refills may take 3-4 days to be refilled. Please do not leave multiple messages for this may slow down the process.
Triplicates: Patients who receive triplicate medication for controlled substances must be seen every 90 days unless the provider has approved in order to receive their monthly prescriptions. Each prescription must be picked up by the patient or have a signed release plus proof of ID. There is a $5 fee for each monthly script pickup. If a prescription is lost or not filled within the allowed time frame and we have to issue a new prescription a $10 fee will be charged**. For monitoring purposes a urine toxicology screen is mandatory for all patients receiving triplicates**.
Controlled Medications: All patients that receive chronic pain medications must be seen every month by our providers unless prior approval has been documented. Each patient is required to sign an agreement that they will not receive medications from another facility or doctor. **For monitoring purposes a urine toxicology screen is mandatory for all patients receiving controlled medication**. Medications will only be done during business hours and not through our answering service.

MEDICAL RECORDS:_____
There is a $25 fee for the first 20 pages of any medical record and must be paid prior to release. A signed medical records release form must be signed and 72 hr advance request is required. For any forms that need to be filled out and signed by a physician a $25 fee must be paid in advance and a 72 hr advance notice is required. This includes FMLA, disability, medical supplies, or any formal document needing a physician letter.

REFERRALS AND/OR AUTHORIZATIONS: ______
Please allow 72 hours for all referrals and authorizations to be processed.

MINORS: _________
All patients under the age of 18 years of age, will need to be accompanied by a parent or legal guardian. Parent or legal guardian must be present through the entire duration of the appointment. If a parent or legal guardian is unavailable to accompany the patient, then a MEDICAL TREATMENT AUTHORIZATION form must be completed giving another adult permission to accompany the patient

Please list the individuals who we are allowed to discuss medical information with:

Name: ____ Relationship:____
Name: ____ Relationship:____
Name: ____ Relationship: ____

Do you consent to a medical exam and any procedures or test deemed necessary by our providers while you are in our office? YES/ NO

Do you consent Woodlands Internists to leave test result information on your voicemail? YES /NO

Do you consent for our office to release medical information to any specialist that we refer you to or that you are currently being treated by? YES/NO

Please list all specialists that you are currently being treated by:

Physician:__________________________________ Specialty: _________________________ Phone #: __________________________
Physician: _________________________________ Specialty: _________________________ Phone #: __________________________
Physician: _________________________________ Specialty: _________________________ Phone #: __________________________
Physician: _________________________________ Specialty: _________________________ Phone #: __________________________

I have read, understand and agree with all of Woodlands Internists PA policies and procedures:

Print name : ___________________________ Signature:_____________________________ Date:_________________________