21720 Kingsland Boulevard Suite 303 A
Katy, TX 77450
Phone: (281) 579-5638
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PATIENT INFORMATION

Name: ______________________________ Date of Birth: ___________ Age: ___ Sex: ___

Address: ____

Cell Phone: ___________ Home Phone: ___________ E-mail: _______________________

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced Employed By: ______________

Family Physician: ______________________________________ Phone: ______________

Pharmacy: ____ Phone: ______________

In Case of an Emergency, Contact: ____

Relationship to Patient: __________________________________ Phone: ______________

How were you referred to our practice? ____

Have you had any testing done recently? ☐ Yes ☐ No (*If Yes, please list name of test, date & place of service below*)

____

What will you be seen for today? (*Check all appropriate boxes*)

☐ **Weight Loss Surgery**
☐ **Hiatal Hernia**
☐ **Barrett's Esophagus**
☐ **Other** (*Please write below*)
☐ **Abdominal Pain**
☐ **Inguinal Hernia**
☐ **Colon / Intestine**
☐ **Acid Reflux / GERD**
☐ **Ventral / Belly Button Hernia**
☐ **Gallbladder / Gallstones**

Please describe in your own words the purpose of today's visit and all of your current symptoms:

____

____

MEDICAL HISTORY: (*Check all appropriate boxes that you currently have or have been diagnosed with in the past*)

☐ **Heart Attack / Heart Failure**
☐ **History of Heart Stent Placement**
☐ **Diabetes – Non-Insulin**
☐ **Diabetes – Insulin**
☐ **High Blood Pressure**
☐ **High Cholesterol**
☐ **Blood Clots (i.e. Legs)**
☐ **Sleep Apnea**
☐ **Rheumatologic condition (i.e. Lupus)**
☐ **Pulmonary Embolism**
☐ **Cirrhosis of the Liver**
☐ **Taking Steroids (i.e. Prednisone)**
☐ **Fatty Liver**
☐ **History of Stroke**
☐ **Hepatitis B / C**
☐ **HIV Positive**
☐ **Osteoarthritis**
☐ **Reflux/GERD**
☐ **Back Pain**
☐ **Asthma**
☐ **Pregnancy**

MEDICATIONS: (*List all medications you are currently taking*)

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____

____

DRUG ALLERGIES:

____

____

____

PAST SURGICAL HISTORY: (*List all surgeries you have had*)

Year:	Type of Surgery:	Complications: (*If any*)

FAMILY HISTORY: (*Check all appropriate boxes*)

Disease:	Relationship to Patient:
☐ Cancer	
☐ Diabetes	
☐ Heart Disease	
☐ Other (*Please write*)	

HEALTH HABITS: (*Check all appropriate boxes*)

Habit:	How Much Per Day?
☐ Caffeine & Type	
☐ Tobacco	
☐ Street Drugs	
☐ Alcohol	

Your Environment Exposes You To:	
☐ Stress	☐ Hazardous Substances
☐ Heavy Lifting	☐ Other

Have you ever had a blood transfusion? ☐ Yes – *Approximate Date*: ____________________ ☐ No

REVIEW OF SYSTEMS: (*Check all appropriate boxes of symptoms you currently have*)

General
☐ Chills
☐ Dizziness
☐ Fainting
☐ Fever
☐ Headache

Gastrointestinal
☐ Blood per rectum
☐ Constipation
☐ Diarrhea
☐ Nausea
☐ Hemorrhoids

Eye, Ear, Nose, Throat
☐ Bleeding Gums
☐ Double Vision
☐ Earache Difficulties
☐ Hay Fever
☐ Hoarseness

Men Only
☐ Breast Lump
☐ Erection Difficulties
☐ Lump in Testicles
☐ Penis Discharge
☐ Sweats

Genito-Urinary
☐ Blood in Urine
☐ Frequent Urination
☐ Painful Urination

Muscle/Joint/Bone
Pain, Weakness or Numbness in:
☐ Arms
☐ Back
☐ Feet
☐ Hands
☐ Hips
☐ Legs
☐ Neck
☐ Shoulders

Cardiovascular
☐ Chest Pain
☐ Irregular Heart Beat
☐ Blood Clots

Skin
☐ Bruise Easily
☐ Hives
☐ Itching
☐ Change in Moles
☐ Sores that won't heal

Women Only:
☐ LMP date: ___________
☐ Pregnant: _____months
☐ Abnormal Pap Smear
☐ Breast Lump
☐ Nipple Discharge

To the best of my knowledge, the above information is complete and correct. I understand it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

____
Signature of Patient, Parent, Guardian or Personal Representative

____
Date

____
Please Print Name of Patient, Parent, Guardian or Personal Representative

____
Relationship to Patient