MAIN STREET MEDICAL CLINIC

Patient Information Form

PATIENT INFORMATION

NAME: _____
(First) (Middle initial) (Last)

EMAIL: _____

ADDRESS: _____
(Number and street) (Apt #) (City) (State) (Zip code)

PRIMARY PHONE #: _____ SECONDARY PHONE #: _____

DATE OF BIRTH: _____ GENDER: Female ☐ Male ☐

MARITAL STATUS: _____ RACE: _____

PRIMARY LANGUAGE: _____ SS #: _____

ETHNICITY: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Unknown/Declined

EMPLOYER/SCHOOL:_____

PHARMACY NAME: _____ Phone: _____

Pharmacy Address: _____

IN CASE OF AN EMERGENCY

NAME: _____ RELATIONSHIP: _____

PHONE #: _____ ALTERNATE PHONE #: _____

HEALTH INSURANCE INFORMATION

*Note: MSMC is not responsible for verification of in-network participation with your insurance carrier. **Initial here**: _____

PRIMARY INSURANCE: _____ INSURANCE NAME: _____

ID #:_____GROUP #: _____

POLICY OWNER NAME: _____

POLICY OWNER DOB:_____RELATIONSHIP TO PATIENT: _____

SECONDARY INSURANCE: _____ INSURANCE NAME: _____

ID #: _____ GROUP #: _____

POLICY OWNER NAME: _____

POLICY OWNER DOB:_____RELATIONSHIP TO PATIENT: _____

I authorize the release of any medical information necessary to process billing to my insurance company and request payment of benefits to Dr. Abbas Jafri, MD PA. I acknowledge that I am financially responsible for the payment whether or not it is covered by my insurance. This authorization should continue until such time that I revoke it in writing.

Signature: _____ Date: _____

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COMPREHENSIVE ADULT NEW PATIENT HEALTH HISTORY QUESTIONNAIRE

Name:_____Date: _____

Your answers on this form will help your healthcare provider get an accurate history of your medical concerns and conditions. It is long because it is comprehensive. We really want to know you well so we can properly care for you. If you cannot remember specific details, please provide your best guess. If you are uncomfortable with any question, do not answer it. Thank you!

Who referred you to this practice? ☐ patient ☐ family member ☐ physician

Main reason for today's visit: _____

Other concerns: _____

What are your health goals for the next year?

_____

How would you rate your health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

List any medical suppliers you use (e.g. respiratory supplies, etc):

_____

_____

MEDICATIONS: Please list (or show us your own printed record) **all** prescriptions and non-prescription medications. This includes vitamins, herbs, supplements, home remedies, birth control pills, inhalers, over the counter pain pills (Advil, Aleve, Tylenol, etc).

☐ I do not take any prescription or over the counter medications.

☐ I brought a list of my medications (please provide list to MSMC staff and don't write in medications below).

Medication	(e.g. ma/pill)	many times per day?

☐ NONE

ALLERGIES or intolerance to medications?

(If yes, to what & what reaction?)

_____

IMMUNIZATIONS: Enter year *(if known)* of any vaccinations you have had.

Tetanus (Td) _____ With Pertussis (Tdap) _____ Varicella (Chicken Pox) shot or illness _____

Pneumovax (pneumonia) _____ Influenza (flu shot) _____ Hepatitis A _____ Hepatitis B _____

MMR_____Meningitis_____Zostavax (Shingles)_____HPV _____

HEALTH MAINTENANCE SCREENING TESTS

Sigmoidoscopy / Colonoscopy *(circle one)* Year: _____ Abnormal? ☐ No ☐ Yes Polyp? ☐ No ☐ Yes

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Women only:

Mammogram	Most recent date/where: _____	Abnormal? No ☐ Yes ☐
Pap Smear	Most recent date/where: _____	Abnormal? No ☐ Yes ☐
Bone Density Test	Most recent date/where: _____	Abnormal? No ☐ Yes ☐

PERSONAL MEDICAL HISTORY

Do you have now or have you had (in the past) any of the following conditions?

Condition	Now	Past	Comments
Alcohol/Drug Abuse			
Allergy (Hay Fever)			
Anemia			
Anxiety			
Arthritis (Rheumatoid)			
Arthritis (Osteoarthritis)			
Asthma			
Bladder/Kidney Problems			
Blood Clot (leg)			
Blood Clot (lung)			
Blood Transfusion			
Breast Lump (benign)			
Cancer Breast			
Cancer Colon			
Cancer Other Type			
Cancer Ovarian			
Cancer Prostate			
Cataracts			
Chicken Pox			
Colon Polyp			
Coronary Artery Disease			
Depression			
Diabetes (adult onset)			
Diabetes (childhood onset)			
Diverticulosis			
Emphysema (COPD)			
Fractures (broken bones)			Where?
Gallbladder Disease			

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Gastroesophageal Reflux (Heartburn/GERD)			
Glaucoma			
Gout			
Gynecological Conditions (Endometriosis)			
Gynecological Conditions (Fibroids)			
Gynecological Conditions (Other)			
Heart Attack			
Hepatitis - Type A			
Hepatitis - Type B			
Hepatitis - Type C			
Hepatitis - Other			
High Blood Pressure			
High Cholesterol			
Hip Fracture			
Irritable Bowel Syndrome			
Kidney Disease/Failure			
Kidney Stones			
Liver Disease			
Migraine Headaches			
Osteoporosis			
Pneumonia			
Prostate (enlargement)			
Prostate (nodules)			
Seizure/Epilepsy			
Skin Condition (Eczema)			
Skin Condition (Psoriasis)			
Skin Condition (Abnormal Moles)			
Sleep Apnea			
Stomach Ulcer			
Stroke			
Thyroid (Nodule)			
Thyroid High (Overactive) / Hyperthyroidism			
Thyroid Low (Underactive) / Hypothyroidism			
Other *(list)*			

☐ Check box if you have no history of significant medical illnesses.

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SURGICAL & PROCEDURE HISTORY

Please check off any procedure or surgeries. List any abnormal finding, details or complications under comments.

Surgical Procedure	Yes	Year	Comments
Abdominal surgery			
Angiogram (heart)			
Angiogram (vascular)			
Appendectomy (appendix removal)			
Back surgery (lumbar)			
Biopsy *(location in comments)*			
Breast Biopsy *(location in comments)*			**Circle**: Right / Left / Both
Breast Surgery			**Circle**: Right / Left / Both
Cataract Surgery			
Colonoscopy			
Coronary Bypass			
Coronary Stent			
C-Section			
Echocardiogram (heart)			
EGD (Stomach Endoscopy)			
Gallbladder Removal			**Circle**: Laparoscopic
Heart Surgery *(other than coronary bypass checked above)*			
Hip Surgery			**Circle**: Right / Left / Both
Hysterectomy (partial, ovaries left)			**Circle**: Laparoscopic / Vaginal / Abdominal
Hysterectomy (total, including ovaries)			**Circle**: Laparoscopic / Vaginal / Abdominal
Knee Surgery			**Circle**: Right / Left / Both
LEEP (Cervix surgery)			
Neck (Spine) Surgery			
Ovary Removal			**Circle**: Right / Left / Both
Pulmonary Function Test			
Sigmoidoscopy			
Sinus Surgery			
Stress Test (stress echo)			
Stress Test (thallium/perfusion)			
Stress Test (treadmill)			
Tonsillectomy			
Tubal Ligation			
Vasectomy			
Other *(list)*			

☐ Check box if you have <u>never</u> had any medical procedures or surgeries

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FAMILY HISTORY

Adopted? ☐ No ☐ Yes

If adopted and you do not know your family history, skip this section and continue to Health Issues on the next page.

Indicate which relative has had the following diseases (parents & siblings are the most important). Write in the number of siblings in appropriate boxes.* If some siblings are alive and some are deceased, use the space to the right to explain further.

	Mother	Father	Sister(s)	Brother(s)	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad		
Alive										
Deceased										
Age currently or at death										
Diseases & Conditions	Mother	Father	Sister(s)	Brother(s)	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Other blood relatives (list relationship to you)	List age(s) at diagnosis if known and if this was the cause of death
No significant history known										
Hypertension - high blood pressure										
Hyperlipidemia - high cholesterol										
Heart Attack, Angina (Coronary Artery Disease)										
Diabetes Type II (adult onset)										
Cancer, Breast										
Cancer, Colon										
Cancer, Prostate										
Osteoporosis										
Depression										
Alcoholism/Drug Abuse										
Alzheimer's										
Asthma										
Autoimmune Disease										
Bleeding or Clotting Disorder										
Cancer, Lung										
Cancer, Ovarian										
Cancer, Other Type										
Colon Polyp										
Diabetes Type I (childhood onset)										

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Emphysema (COPD)									
Genetic Disorder (explain)									
Glaucoma									
Heart Disease (CHF)									
Heart Disease (Other)									
Hepatitis B or C									
Hip Fracture									
Hypothyroidism/Thyroid Disease									
Kidney Disease									
Kidney Stones									
Macular Degeneration									
Stroke									
Sudden Cardiac Death									
Other *(list)*									

HEALTH ISSUES

Tobacco Use:

Smoke or smoked any of the following? ☐ Cigarettes ☐ Pipe ☐ Cigars

Exposure to second-hand smoke? ☐ No ☐ Yes

(If never used any tobacco, skip to Alcohol Use section below)

Current smoker: Packs/day: _____ # of years: _____

Former smoker: Quit date: _____ Packs/day did you smoke? _____ Years you smoked? _____

Other tobacco (check if applicable)? ☐ Snuff ☐ Chew Quit date: _____

Are you ready to quit? ☐ No ☐ Yes

Alcohol Use:

Do you drink alcohol? ☐ No ☐ Yes Number of drinks/week: _____ ☐ Beer ☐ Wine ☐ Liquor

Drug Use:

Have you **ever** used recreational drugs? ☐ No ☐ Yes

Any used currently? _____

Sexual Activity:

Are you sexually involved? ☐ Not currently ☐ Never ☐ Yes

Birth control method or STD prevention (check all that apply):

☐ None needed ☐ Condom ☐ Pill ☐ IUD ☐ Patch ☐ Ring

☐ Diaphragm ☐ Vasectomy ☐ Tubal ligation ☐ Other method (specify): _____

Diet:

Do you follow a special diet? ☐ No ☐ Yes Vegetarian / Vegan / Gluten-free / Other: _____

Exercise:

Do you exercise regularly? ☐ No ☐ Yes If yes, what kind of exercise? _____

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MEDICAL FORMS

Please check any of the following forms you have completed:

☐ Advanced Directive for Health Care (ADHC) ☐ Durable Power of Attorney (DPA) for healthcare decisions

☐ Living Will ☐ POLST (Physician Orders for Life Sustaining Therapy)

☐ Know about these or have the forms but have not completed them ☐ I don't know what these are

PHQ 2 – Brief Emotional/Behavior Assessment

Over the past 2 weeks, have you often been bothered by either of the following problems?

Little interest or pleasure in doing things	YES	NO
Feeling down, depressed, or hopeless	YES	NO

WOMEN'S HEALTH HISTORY

# of pregnancies:_____# of births:_____# of miscarriages:_____# of abortions: _____

Age at beginning of periods (menstruation): _____

Age at end of periods (menopause/hysterectomy): _____ ☐ N/A

Do you have concerns about your period or menopause you'd like to discuss? ☐ No ☐ Yes

If you're having periods, how often do they occur? Every_____days. How long do they last?_____days.

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Medical Records Release Authorization

Upon presentation of this authorization you are requested to provide the records outlined below to:

To Recipient: Dr. Abbas Jafri, MD, FACP
Phone: (281) 528-4100 Fax: (281) 528-4099
1120 Medical Plaza Drive, Suite 335 The Woodlands, Texas 77380

From Clinic/Hospital: _____

Patient: _____
(Patient Name) (Phone) (DOB)

Dates of Service (Check One and Complete Dates of Service if Required)
☐ Please provide a complete copy of my file for all dates of service
☐ Please provide a complete copy of my file for service from_____through _____

Records to Be Released (45 CFR 164.508(c)(1)(i))
☐ All Records ☐ Emergency Room Records ☐ Lab/Pathology Reports ☐ History & Physical ☐ Operative Reports
☐ Radiology Reports ☐ Consultation Reports ☐ Discharge Summary ☐ Billing ☐ Images ☐ Other

Purpose for Disclosure: ☐ Disability ☐ Insurance ☐ Attorney ☐ Referring Physician ☐ Patient Request ☐ Other

Please indicate your acceptance by checking the following boxes:

☐ I understand that I may revoke this authorization in writing at any time to the extent that action has been taken in reliance upon this authorization (45 CFR 164.508(c)(2)(i)).
☐ I understand that treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre-employment purposes (45 CFR 164.508(c)(2)(ii)).
☐ I understand that my records are confidential and cannot be disclosed without my written authorization except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I understand that the specific information to be released may include but is not limited to: history, diagnosis, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) (45 CFR 164.508(c)(2)(iii)).

This authorization will expire one-hundred and eighty (180) days from the date of my signature unless I revoke the authorization prior to that time.

Date: _____

Signature: _____
Patient or Legally Authorized Representative

Signature: _____
Printed Name of Patient or Legally Authorized Representative