

TCFPA Medical Centers New Patient Information (Please bring with you to your 1st office visit)Physician: Cornwell Dant Denman Greene Kowalski Ireland Phillips SmithDate / /2010Referred By Do you have a living Will? Yes No Patient: First Name Middle Name Last Name Street Address
 Apt No. or POBox City State Zip code Date of Birth: / / Sex M F Marital Status S M D W Social Security No. - - Phone Number () - extension **Guarantor (If patient is a minor, please complete this section for billing purposes)**Patient: First Name Middle initial Last Name Street Address
 Apt No. or POBox City State Zip code Date of Birth: / / Sex M F Social Security # - - Phone Number () - extension **Patient or Guarantor** (if not employed then check one of the following Retired Student other)Employer Street Address City State Zip code Spouses Name Date of Birth: / / Social Security No. - - Phone Number () - extension Emergency Contact Person (other than Home number) Relationship Phone Number () - **Medical Insurance Information (We Need A Copy of your Insurance Card)**

I, the undersigned, give my permission to treat and assign directly to Memorial Health Partners, if any, otherwise payable to me for services rendered. I the undersigned understand that I am financially responsible for all charges not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits and authorize the use of this signature on all insurance submissions.

Signature _____ Date _____

TCFPA Medical Center
Medical History Form

Patient Name _____

Birthdate //

Date of Last Physical Exam _____

Your Occupation _____

Place of Employment _____

SpousesOccupation _____

Education Level High School College Masters Ph.D. Other _____

Religious Preference _____

Hobbies _____

Smoking History. Packs Per day _____

For how many years _____

Drinking History Ounces Per day _____

For how many years _____

List the individuals that live in your home _____

How much exercise do you get. Minutes each day ____ Hours per week ____

What additional information should the doctor have about you? _____

List the reasons that you want to see the doctor. (List in order of importance to you)

1. _____

2. _____

3. _____

List other physicians seen in the past 2 years. _____

Past Medical History:

1. Operations (list all and give year)

a. _____

d. _____

b. _____

e. _____

c. _____

f. _____

2. Accidents (list broken bones, injuries, etc.)

a. _____

d. _____

b. _____

e. _____

c. _____

f. _____

3. Illnesses (list problem and year)

a. _____

d. _____

b. _____

e. _____

c. _____

f. _____

4. Hospitalizations (list all and give year)

a. _____

d. _____

b. _____

e. _____

c. _____

f. _____

5. Are you allergic to Yes or No

a. Penicillin Yes No

e. Demerol Yes No

b. Sulfa drugs Yes No

f. Barbituates Yes No

c. Codeine Yes No

g. Anesthetics Yes No

d. Aspirin Yes No

f. Other(list) _____

6. Pregnancies _____ Miscarriages _____ Weight of largest Child _____

7. Medications(list all you are taking and have taken in the past Month

a. _____ g. _____ m. _____

b. _____ h. _____ n. _____

c. _____ i. _____ o. _____

d. _____ j. _____ p. _____

e. _____ k. _____ q. _____

f. _____ l. _____ r. _____

Family History	Age	Medical Problems	Cause of death	Age
Father				
Mother				
Brothers - - -				
Sisters - - -				
Spouse				
Children Check one 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 <input type="checkbox"/>				

Review of Systems(Review the list below and check any that describe a problem you are currently having or circle any problem have had in the past.)

- | | | |
|--|--|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Constipation | <input type="checkbox"/> Vaginal Discharge |
| <input type="checkbox"/> Seizures or fits | <input type="checkbox"/> Vomit Blood | <input type="checkbox"/> Back Pain |
| <input type="checkbox"/> Fainting or blackout spells | <input type="checkbox"/> Blood with bowel movements | <input type="checkbox"/> Pain in legs when walking |
| <input type="checkbox"/> Black loose bowel movements | <input type="checkbox"/> difficulty maintaining balance | <input type="checkbox"/> Joint Swelling |
| <input type="checkbox"/> Strokes | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Joint Pain |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> Chronic Weakness |
| <input type="checkbox"/> Difficulty with Vision | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Nose Bleeds | <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Dry Skin |
| <input type="checkbox"/> Change in Voice | <input type="checkbox"/> Weight Gain in past year | <input type="checkbox"/> Hair Loss |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Frequent urination(passing water) | <input type="checkbox"/> Hives |
| <input type="checkbox"/> Swelling in ankles or feet | <input type="checkbox"/> Pain on urination | <input type="checkbox"/> Breast Discharge |
| <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Pus or milky color of urine | <input type="checkbox"/> Lumps in Breast |
| <input type="checkbox"/> Chest Pain or Chest tightness | <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Painful Breast |
| <input type="checkbox"/> Heart Attacks | <input type="checkbox"/> Pass a stone in urine | <input type="checkbox"/> Easy Bruising |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Reduction in force of urine | <input type="checkbox"/> Excessive bleeding after cutting |
| <input type="checkbox"/> Coughing up blood | <input type="checkbox"/> Difficulty starting urine stream | <input type="checkbox"/> Crying Spells |
| <input type="checkbox"/> Wheezing during Breathing | <input type="checkbox"/> Leakage of Urine | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Sugar Diabetes | <input type="checkbox"/> Difficulty with Erection | <input type="checkbox"/> Mood Swings |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Discharge from Penis | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Onset of Menstruation(age)_____ | <input type="checkbox"/> Difficulty with Memory |
| <input type="checkbox"/> Fever for more than 5 days | <input type="checkbox"/> Painful Periods | <input type="checkbox"/> Chronic Fatigue |
| <input type="checkbox"/> Trouble Swallowing | <input type="checkbox"/> Irregular Periods | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Chronic Diarrhea | <input type="checkbox"/> Last Menstrual Period_____ | <input type="checkbox"/> Pain in hands or feet with cold
Weather exposure |

Weight at age 20 _____

Weight 1 year ago _____

Weight Now _____

Date Reviewed _____

Physician Signature _____

