Whitesboro FAMILY Medical Clinic

Amy Dangelmayr, FNP-C • Llogan Yosten, FNP-C

CONFIDENTIAL PATIENT INFORMATION

Date:_____

First Name:_____**Last Name:**_____**DOB:**_____

Mailing Address:_____

City:_____**State:**_____**Zip Code:**_____

Home Phone:_____**Cell Phone:**_____

Male:_____**Female**_____**Social Security Number:**_____

Email Address:_____

Circle One: Married Single Partnered Widowed

Name of Spouse/Partner/Significant other (if applicable):_____

Patient Employed By:_____**Business Phone:**_____

Name of Responsible Party:_____

Do you have health insurance? YES / NO

Emergency Contact:

Name:_____**Relationship:**_____**Phone:**_____

Whitesboro Family Medical Clinic, LLC
304 Charlie Drive
Whitesboro, Texas 76273
903-564-3503

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PATIENT HEALTH HISTORY PG 1 of 2

Name_____ **Age:**_____ **Birthdate:**_____ **Gender:**_____
Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed **Orientation:** ☐Heterosexual ☐ Homosexual ☐ Bisexual
Currently Living: ☐Alone ☐With Family ☐ With Friends ☐With Significant Other
Profession (job):_____ ☐ Working, Employed By:_____ ☐Retired

GENERAL
- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Fatigue
- ☐ Difficulty Sleeping
- ☐ Forgetful

EYE, EAR, NOSE, THROAT
- ☐ Visual Changes
- ☐ Double Vision
- ☐ Ringing in the ears
- ☐ Hearing Loss
- ☐ Ear Pain
- ☐ Sinus Congestion or Pain
- ☐ Nosebleeds
- ☐ Hoarseness
- ☐ Difficulty Swallowing

DERMATOLOGICA
- ☐ Psoriasis
- ☐ Changes in moles
- ☐ Warts
- ☐ Rash

RESPIRATORY
- ☐ Wheezing
- ☐ Coughing
- ☐ Shortness of breath
- ☐ Emphysema/COPD

PSYCHIATRIC
- ☐ Anxiety
- ☐ Depression
- ☐ Moody
- ☐ Irritable
- ☐ Suicidal thoughts

CARDIOVASCULAR
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Murmur
- ☐ Rapid Heartbeat
- ☐ Heart Attack

GASTROINTESTINAL
- ☐ Abdominal Pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Rectal Bleeding

MUSCLE, JOINT, BONE
- ☐ Muscle Pain
- ☐ Joint Pain
- ☐ Weakness
- ☐ Gout

NEUROLOGICAL
- ☐ Dizzy
- ☐ Loss of conciseness
- ☐ Siezures
- ☐ Numbness
- ☐ Frequent Headaches

ENDOCRINE
- ☐ Thyroid Problems
- ☐ Diabetes
- ☐ Hot Flashes
- ☐ Night Sweats
- ☐ Irregular Menses

QUESTIONS

Do you smoke?_____
_____Per Day
_____Per Week
_____Per Month

Do you smoke or use any form of THC? _____
If yes, what form? _____
How often?: _____

Do you vape? _____
If yes, how long? _____
How many cartridges per day? _____

Any other illicit drug use?
_____

Do you drink alcohol? ___
_____Per Day
_____Per Week
_____Per Month

Do you drink caffeine?___
_____Per Day
_____Per Week
_____Per Month

Do exercise?___
_____Per Day
_____Per Week
_____Per Month

Colonoscopy?___**Y**___**N**
Date:_____

Bone Density?___**Y**___**N**
Date:_____

MEN ONLY

Pain or lumps in testicles?
___**Y**___**N**

Penile (penis) itching, burning or discharge?
___**Y**___**N**

Prostate Disease or problems?___**Y**___**N**

Problems starting or stopping your urine stream?
___**Y**___**N**

Wake in the night to go to the bathroom?___**Y**___**N**

Sexual problems or concerns?___**Y**___**N**

WOMEN ONLY

Number of
_____ **pregnancies**
_____ **births**
_____ **miscarriages**
_____ **abortions**

Birth Control Method:
_____

Sexual problems or concerns?___**Y**___**N**

Vaginal itching, burning or discharge?___**Y**___**N**

Wake in the night to go to the bathroom?___**Y**___**N**

Mammogram?___**Y**___**N**
Date:_____

Date of last Pap Smear
_____

Hysterectomy?___**Y**___**N**
If yes, do you still have your ovaries? ___Y___N

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PATIENT HEALTH HISTORY PG 2 of 2

CONDITIONS: Check all you have or have had in the past

☐ AIDS	☐ Cancer	☐ HIV Postitive	☐ Thyroid Problem
☐ Alcoholism	☐ Cataracts	☐ Kidney Disease	☐ Tuberculosis
☐ Anemia	☐ Chemical Dependency	☐ Liver Disease	☐ Ulcers
☐ Anorexia	☐ Diabetes	☐ Migraine Headaches	☐ Sleep Apnea
☐ Appendicitis	☐ Emphysema	☐ Mononucleosis	☐ Sexual Transmitted Disease
☐ Arthritis	☐ Epilepsy	☐ Multiple Sclerosis	Type:_____
☐ Asthma	☐ Glaucoma	☐ Pacemaker	☐ Other (please list)
☐ Bleeding Disorders	☐ Goiter	☐ Pneumonia	_____
☐ Breast Lump	☐ Heart Disease	☐ Psychiatric Care	_____
☐ Bulimia	☐ Hepatitis	☐ Stroke	_____

SURGERIES/HOSPITALIZATIONS: List all Surgeries

Surgery	Year	Reason	Physician

MEDICATIONS: List all medications you take (including over the counter herbs and medications taken)

Medication	Strength	How Often	Reason

ALLERGIES: List all allergies (medications, foods)

Allergy	Physician

FAMILY HISTORY: List diseases and age of death

Family Member	Disease(s)	Age of Death
Father		
Mother		
Paternal Grandfather		
Paternal Grandmother		
Maternal Grandfather		
Maternal Grandmother		

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PROTECTED HEALTH INFORMATION DISCLOSURE

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM WHITESBORO FAMILY MEDICAL CLINIC, LLC MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, PLEASE FILL OUT THE LIST BELOW.

I give permission for my Protected Health Information to be disclosed for purposes of communication results, findings and care decisions to the family members and/or others listed below:

Name:_____ **Phone:**_____

Name:_____ **Phone:**_____

Patient/Representative may revoke or modify this specific authorization and that revocation or any modifications must be in writing.

_____ _____

Signature **Date**

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903-564-3503

Whitesboro Family Medical Clinic, LLC.

304 Charlie Dr. Whitesboro TX 76273

(903) 564-3503 FAX (940) 435-7057

PATIENT AUTHORIZATION TO DISCLOSE

PERSONAL HEALTH INFORMATION

Patient: _____

Address: _____

Date of Birth: _____

Whitesboro Family Medical Clinic is authorized to furnish to/ received from (circle desired choice)

Recipient/ Disclose: _____

For the purpose of: _____

I AUTHORIZE THE RELEASE OF THE FOLLOWING MEDICAL RECORDS.

___ **I GIVE PERMISSION TO RELEASE ALL MY MEDICAL RECORDS** including information and records or copies of records relating to the history, diagnosis, treatment or services rendered to me in connection with my condition or disease. Thus includes permission to release POTENTIALLYSENSITIVE INFORMATION which may include information concerning my treatment of mental illness, Human Immunodeficiency Virus (HIV), alcoholism, drug use/dependency, venereal disease, sexual assaults, abortion, illegitimacy of birth, communications to social workers and/or psychotherapies, psychologist, if any.

X **I GIVE PERMISSION TO RELEASE ALL MY MEDICAL RECORDS** specifically described below:

_____

_____

I release Whitesboro Family Medical Clinic and the Recipient/ Discloser listed above, and any of their providers and staff from all responsibility or liability that may arise from this authorization. I may withdraw this authorization at any time by giving written notification to Whitesboro Family Medical Clinic, providing that I do so in writing and to the extent that you have already disclosed the information in reliance on this authorization.

This authorization expires on _____ (optional) if no date is given, then this authorization shall remain in effect for the period reasonably needed to complete the request.

_____ _____

Patient Signature (Patient's Representative if minor) Date

So that we may improve our patient care, please let us know the reason you are requesting this record release.

_____ Not satisfied with Provider, (which provider? _____)

_____ Not satisfied with staff (which staff member? _____)

_____ Moving out of the area.

_____ Other (please specify _____)

ONLY FAX TO 940-435-7057