Family Medical Clinic
2840 Keller Springs Road, Suite 601
Carrollton, Texas 75006
Phone: 972-512-0243
Email: info@springcareclinic.com
Website: www.springcareclinic.com

PATIENT INTAKE AND HISTORY FORM

Name: _____ **Social Security #:** _____ **DOB:** _____

Address: _____

Phone Number: _____ **(ok to leave voice message: Y N)**

Email Address: _____
(ok to contact by email: Y N)

Sex/Gender: (circle one) Male, Female, Intersex, Transgender Female-to-Male or Male-to-Female

Race: (e.g.: African-American, Latino, Asian, etc): _____

Ethnicity: (e.g.: Mexican, Hawaiian, Irish, etc): _____

Education Level: _____ **Occupation:** _____

Number of hours Worked per Week: _____ **Religious/Spiritual Beliefs:** _____

Relationship/Marital Status: _____

Emergency Contact Name: _____ **Phone Number:** _____

How did you hear about us? Advertisement, Billboard, Google, Word of mouth, Social Media, other_____

Language spoken most often:_____**Do you need an interpreter? ◯ Yes ◯ No**

Preferred Local Pharmacy: _____

Do you use a mail order pharmacy?_____If so, please be sure we have your pharmacy provider information and a copy of your prescription drug card.

Preferred Mail Order Pharmacy: _____

*****Should your information change, please report these changes in your address, phone contact numbers, insurance, or emergency contact, information to the front desk upon check in at future visits*****

Reason(s) for coming to the doctor today:

_____

_____

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- Has a previous Provider provided treatment for the reason you are being seen today?

If yes, please provide Provider information. _____

- Do you currently **follow up with any other Provider/Specialist?** (Example: Cardiology, Neurology, Urology, Endocrinology, Infection disease, Mental Health, Nephrology, Therapy, Optometry, Orthopedics, ENT.)
-

If so please list the provider(s) you are following up with:

_____

_____

Healthcare Maintenance Screening (please list the most recent date if applicable)

	Date completed	**Who and Where performed or administered?**
Date of Colonoscopy:		
Date of Mammogram:		
Date of Last Prostate Exam:		
Date of Last Pneumonia shot: Prevnar or Pneumovax 23		
Date of Last Flu shot:		
Date of Last Eye Exam:		
Date of Last Bone Denisty Study (DEXA):		
Date of Last Pap Smear:		
Date of Last Tetanus Shot:		
Date of Last Zostavax (Shingles Vaccine):		

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Problem List/Past Medical History:

Have you been diagnosed with any of the following (currently or in the past)?

___ Abdominal Pain
___ Abnormal Vaginal Bleeding
___ Anemia
___ Anxiety
___ Arthritis
___ Asthma
___ Back Pain
___ Cancer
___ Colitis, Ulcerative
___ COPD
___ Crohn's
___ Deep Vein Thrombophlebitis
___ Dementia
___ Depression
___ Diabetes
___ Diverticulitis
___ Dizziness
___ ED (erectile dysfunction)
___ GI Bleed
___GERD
___Gout
___Headaches, Chronic
___Heart Disease
___Heart Murmur
___Heart Palpations
___Hemorrhoids
___Hepatitis
___High Blood Pressure
___Incontinence
___Irritable Bowel
___Kidney Stone(s)
___Measles
___Migraines
___MRSA Infection
___Mumps
___Osteoporosis
___Polio
___Guillain Barre Syndrome
___Prostate Disease
___Rash
___Rheumatic Fever
___Rubella
___Scarlet Fever
___Seasonal Allergies
___Seizure
___Sinusitis
___Sleep Disorder
___Somnolence
___Stroke
___Tendinitis
___Thyroid Disorder
___Tuberculosis
___Ulcer
___Urinary Frequency
___Urinary Pain
___Vascular Disease, Peripheral

List any other important **medical condition**(s) and **or Surgeries** you have had (do not include common colds or flu). Include date or age of initial diagnosis/surgery if possible: (continue on back if necessary)

Problem/Previous Diagnosis *Date(s) or Age*

Allergy History:

List known allergies (including medication allergies) and reaction to allergen. Or check one of the boxes below:

☐ No Known Allergies (NKA) ☐ No Known Drug Allergies (NKDA)

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Medication History:

List any medications and vitamins/minerals/herbs that you are currently taking.
Ensure to **include Name, Dose, and Frequency of medication(s).** or Bring Medication Bottles or Completed List with you to appointment.

☐ No Current Meds

_____

_____

_____

_____

_____

_____

Social History:

Do you use tobacco products? ☐Never used ☐Former use ☐Current use ☐Unknown
How often? ☐Rare ☐Social ☐Daily
What type? ☐Cigarettes ☐Chewing Tobacco ☐Cigars

Are you exposed to "second-hand" smoke**?** ☐Yes ☐No
If yes, please indicate by marking the appropriate boxes: ☐Minimal ☐Frequent ☐Daily
☐Family members smoke indoors ☐Family members smoke outdoors only

Please describe your current exercise routine: ☐Inactive ☐Light ☐Moderate ☐Vigorous

Do you drink beverages with caffeine? ☐Yes ☐No
What type? ☐Coffee ☐Tea ☐Carbonated Beverages

Have you ever used any illicit drugs? ☐Yes ☐No
How often? ☐Quit ☐Social Use ☐Regular Use ☐Daily Use
What type? ☐Uses marijuana ☐Uses cocaine ☐Uses methamphetamines

Do you drink beverages with alcohol? ☐Yes ☐No
How often? ☐Occasional use ☐Moderate use ☐Heavy use
What type? ☐Beer ☐Hard Liquor ☐Wine

What is your most recent primary occupation? _____

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Family History:

Has any member of your family been diagnosed with any of the following conditions (include deceased family members)?

	Father	Mother	Father's Father	Father's Mother	Mother's Father	Mother's Mother	Sister	Brother	Son	Daughter
Heart Disease										
High Blood Pressure										
Stroke										
Cancer										
Glaucoma										
Diabetes										
Epilepsy/Convulsions										
Bleeding Disorder										
Kidney Disease										
Thyroid Disease										
Mental Illness										
Osteoporosis										

List any other important family medical condition(s) you are aware of (do not include common colds or flu). Include date of initial diagnosis if possible:

Family member *medical condition*

_____

_____

Diagnostic Studies: (mark only those that apply)

Dignostic Study	Date Performed	Who and Where Study performed
Angiography (Heart Catheterization:		
Cardiac Stress Test:		
Cardiac Echocardiogram:		
EKG:		
EGD:(esophagogastroduodenoscopy)		
EEG: (electroencephalogram)		
Pulmonary Function Test (PFT):		
Sleep Study:		
Spirometry:		

_____ _____

Patient Signature **Date**

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INSURANCE INFORMATION

Primary Insurance Type: _____

ID: _____ **Subscriber:** _____

Insurance Address: _____

Insurance Phone Number: _____

Secondary Insurance Type: _____

ID: _____ **Subscriber:** _____

Insurance Address: _____

Insurance Phone Number: _____

I have presented evidence of valid insurance coverage, as of this date below to SpringCare. I understand that I am financially responsible for all charges incurred for services provided. I understand that payment is due at the time of services are rendered.

I, _____, hereby assign all medical provider benefits payable (i.e. Payor: Private Insurance company, Medicare, Medicaid, etc.) and related rights existing under the Payor coverage that I have identified in connection with the services provided directly to the SpringCare and acknowledge this includes my permission to submit all my patient health information, including privileged information (i.e. mental health, alcohol/drug abuse or HIV/AIDS, for payment purposes. I understand that any payment received by the SpringCare for this period may be applied to any unpaid bill(s) for which I am liable.