NW CYPRESS
PEDIATRICS AND FAMILY MEDICINE

11240 FM 1960 West, Ste 210
Houston TX 77065
Phone: 281-469-7400
Toll Free: 1-877-563-0817
Fax: 281-469-7403

NEW ADULT PATIENT HISTORY INTAKE

To our new patients: *Welcome* to the NW Cypress Pediatrics and Family Medicine, PLLC. To help us establish you with our practice, please provide us with your complete health history: body, mind and spirit.

Personal History

Name: _____Date of Birth___/____/_____Age____
Date: _____ Email:_____
Are we authorized to send lab results or medical interface to this email address? ☐ NO ☐ YES

Home Address: _____City_____ Zip Code_____
Tel(Home):(____)_____ (Cell):(____)_____ (Work): (___)_____
Occupation _____Employer: _____
Spouse/significant other:_____ Tel:_____
Employer Address: _____City_____ Zip Code_____
Date of Last Examination_____ Your Doctor: _____
Referred by:_____

ALLERGIES:

_____
_____
_____

MAIN PROBLEMS / REASONS FOR THIS APPOINTMENT: (if possible, rank in terms of importance to you)

1. _____
2. _____
3. _____
4. _____
5. _____

Current Medications	Dose	Times Per Day

Current Herbs/Vitamins/Supplements	Dose	Times Per Day

PAST MEDICAL, SURGICAL & TRAUMA HISTORY
List prior illness, injury, hospitalization, surgery, and/or trauma:

Condition	Date(s)

IF NOT NOTED IT IS EITHER NEGATIVE,NON-CONTRIBUTORY,AND/OR NON-PERTINENT.

PERSONAL AND FAMILY HISTORY

Check those that apply:

	Yourself	Mother	Father	Grandparents	Sister/ Brother	Spouse	Children
AIDS/STDs							
Alcoholism							
Allergies							
Alzheimer's							
Anemia							
Arthritis							
Asthma							
Birth Defects							
Bleeding Disorder							
Cancer							
COPD							
Depression							
Diabetes							
Emphysema							
Epilepsy							
Heart Attack							
Heart Trouble							
High Blood Pressure							
IBS							
Kidney Disease							
Liver Disease							
Mental Illness							
Migraine Headaches							
Prostate Cancer							
Sickle Cell Anemia							
Stroke							
Suicide							
Tuberculosis							
Other							

SOCIAL HISTORY (check those that apply):

Marital status: ☐ single ☐ married ☐ divorced ☐ widowed
Education level completed: ☐ below high school ☐ high school ☐ college ☐ professional/trade school
Living arrangement: ☐ alone ☐ family ☐ roommate ☐ significant other
Children: (list sex/ages if applicable):_____
Major stresses in last 6 months ☐ Money ☐ Job ☐ Marriage ☐ Home Life ☐ Other
if other: _____

Pertinent travel history: (out of USA, epidemic areas)

_____
_____
_____

LIFESTYLE / SELF- CARE ISSUES

Do you smoke cigarettes? ☐ YES ☐ NO If yes, how many? _____ packs per day for _____ of years.
Did you ever smoke? ☐ YES ☐ NO If yes, when did you quit? _____ after _____ years.
Do you drink alcohol? ☐ YES ☐ NO If yes, how much? Type_____ & _____ drinks per week
Do you drink caffeinated beverages? ☐ YES ☐ NO If yes, which? _____
Do you use recreational drugs? ☐ YES ☐ NO If yes, which? _____
Do you manage stress well? ☐ YES ☐ NO ☐ NOT SURE ☐ NEED HELP
Do you exercise regularly? ☐ YES ☐ NO If no, why? _____

HEALTH SCREENING HISTORY

List the date of your most recent test or exam.
Mammogram _____ Pap Smear_____ Colonoscopy_____
Blood test for Cholesterol _____ Blood Sugar _____Other Blood Tests_____

Immunizations:
Tdap_____Hepatitis_____Pneumonia_____Flu Shot_____
Others: _____

Recent Radiographic Procedures:
(Xray, MRI, CT Scan, Ultrasound, Bone Scan, Pet Scan, etc): Please include reason and date:

_____
_____
_____
_____
_____

EMERGENCY CONTACT:

NAME *(list 3 contacts)*		PHONE	RELATIONSHIP
1.			
May we disclose all medically needed documents to this emergency contact? ☐ NO ☐ YES			
2.			
May we disclose all medically needed documents to this emergency contact? ☐ NO ☐ YES			
3.			
May we disclose all medically needed documents to this emergency contact? ☐ NO ☐ YES			
Advance Directive: ☐ Full code *or* ☐ Do Not Resuscitate			

This history record has been designed to facilitate our patients continuity of care at **NW Cypress Pediatrics and Family Medicine, PLLC**. This is a confidential record and will be kept in this facility. Information contained here will not be released to anyone without your authorization to do so.

_____ _____

Patient Signature *Date*

_____

Printed name of individual completing form

_____ _____

Signature of individual completing form *Date*