Diagnostic Clinic of Houston
MODERN MEDICINE • SENSITIVE CARE

**Locations**
□ Museum District □ Medical Center
□ W. Houston □ Katy □ Pearland □ Pasadena
**www.diagnosticclinic.com**

## Patient Information

Date_____ **Patient Status**: □ New □ Established □ Consultation □ Referral

Patient Name (Last)_____ (First)_____ (MI)_____ Sex_____
Date of Birth_____ SSN_____ Marital Status_____
Address_____ City _____ State _____ Zip_____
Phone_____ Cell_____ E-Mail_____
Primary Language_____ Religion_____
Race_____ Ethnicity (*Hispanic or Latino*) □ Yes □ No □ Refuse to Report
Emergency Contact_____ Relationship_____ Phone_____

In regards to your healthcare, would you like to receive (*to the information you provided above*):
**Voicemails?** □ Yes □ No **Texts?** □ Yes □ No **E-Mails?** □ Yes □ No **Portal Access?** □ Yes □ No

## Employment

Status: □ Full-Time □ Part-Time □ Retired □ Military Active Duty □ Student □ Unemployed

Employer/School_____ Occupation/Degree Level_____
Address_____ City _____ State _____ Zip _____
Work Phone_____ May we contact you at work? □ Yes □ No

## Insurance

**Type of Medical Coverage?** □ Medicare □ Private/Commercial □ Medicaid □ Self-Pay/Uninsured

**Primary** Insurance_____ Effective Date_____ Type_____
Policy #_____ Group #_____ Relation to Insured_____
**Insured's** Name_____ Date of Birth_____ SS#_____
Billing Address_____ City_____ State_____ Zip_____
Provider Services #_____ Member Services #_____

**Secondary** Insurance_____ Effective Date_____ Type_____
Policy #_____ Group #_____ Relation to Insured_____
**Insured's** Name_____ Date of Birth_____ SS#_____
Billing Address_____ City_____ State_____ Zip_____
Provider Services #_____ Member Services #_____

**Please provide the receptionist your ID and Insurance cards**

- I understand that I am required to give current insurance card(s), photo ID, and other billing information for claims to be filed to any contracted carriers on my behalf. I agree to notify Diagnostic Clinic of Houston of any changes in my insurance coverage or statement address and contact information as soon as possible.
- I understand that I am responsible for notifying the office of any recertification or referrals needed for my insurance.
- I authorize payment of medical benefits be made directly to Diagnostic Clinic of Houston for services rendered. This assignment covers any and all benefits under Medicare, private insurance, other government sponsored programs, and any other health plans.
- In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I will endorse such payments to Diagnostic Clinic of Houston.
- I understand that I am financially responsible for all charges, whether or not paid by insurance, for all services rendered on my behalf.
- I authorize Diagnostic Clinic of Houston to release any information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I understand that my insurance coverage is a contract between myself and my insurance company and I take full responsibility for financial obligations incurred.

THIS AGREEMENT/CONSENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING

_____ _____
**Signature of Patient or Guardian** **Date**

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# Patient Questionnaire

Date_____ **Patient Status**: □ New □ Established □ Consultation □ Referral Date of Birth_____

Patient Name (Last)_____ (First)_____ (MI)_____ Sex_____

What is the principle reason for your visit?_____
What are your symptoms/complaints?_____
When did your symptoms start?_____
What treatments have you tried?_____

## Review of Systems:

Please check all CURRENT symptoms/complaints.

**General**
□ Fatigue
□ Weakness
□ Fever
□ Chills
□ Night Sweats
□ Poor Appetite
□ Weight Loss lbs._____
□ Weight Gain lbs._____

**Eyes**
□ Glasses/Contact
□ Blurred
□ Decreased
□ Doubled
□ Color Blindness
□ Pain
□ Discharge
□ Redness
□ Dry
□ Teary

**Ear/Nose/Throat**
□ Ear Pain
□ Hearing Loss
□ Ear Discharge
□ Ringing in Ears
□ Sensitive to Sound
□ Nasal Congestion
□ Runny Nose
□ Nose Bleeds
□ Ulcers
□ Sinus Problems
□ Sore throat
□ Hoarseness
□ Mouth Sores
□ Tongue Sores
□ Tooth Problems
□ Gum Problems

**Cardiovascular**
□ Chest Pain
□ Palpitations
□ Heart Murmur
□ Poor Circulation
□ Feet/Ankle Swelling
□ Varicose Veins

**Respiratory**
□ Cough
□ Coughing Blood
□ Excess Phlegm
□ Shortness of Breath
□ Wheezing
□ Exposure to Tuberculosis

**Gastrointestinal**
□ Abdominal Pain
□ Abdominal Bloating
□ Nausea
□ Vomiting
□ Diarrhea
□ Constipation
□ Bloody Stool
□ Black/Tarry Stool
□ Excessive Gas
□ Rectal Bleeding
□ Hemorrhoids
□ Acid Reflux
□ Heartburn
□ Trouble Swallowing

**Genitourinary**
□ Frequent Urination
□ Frequent Urination at Night
□ Incontinence
□ Urinary Retention
□ Painful Urination
□ Urine Stream Change
□ Blood in Urine
□ Dark Urine
□ Frequent UTIs
□ Genital Lesions
□ High Risk Sexual Behavior

**Musculoskeletal**
□ Joint Pain
□ Joint Swelling
□ Joint Stiffness
□ Achy Muscles
□ Weak Muscles
□ Bone Pain
□ Back Pain
□ Leg Cramps

**Endocrine**
□ Heat Intolerance
□ Cold Intolerance
□ Excess Sweating
□ Abnormal Skin Pigment
□ Excess Hunger
□ Excess Thirst

**Hema / Lymph**
□ Easy Bruising
□ Excessive Bleeding
□ Blood Clots
□ Swollen Lymph Nodes
Where?_____
_____
_____

**Dermatologic**
□ Acne
□ Mole Changes
□ Excessive Dry Skin
□ Clammy Skin
□ Fungal Nail Infections
□ Jaundice
□ Itching
□ Rash
□ Warts
□ Hives
□ Sore/Ulcers
□ Bruising
□ Scaling
□ Skin Thickening
□ Hair Loss
□ Abnormal Hair Growth
□ Dry/Brittle Hair

**Neurological**
□ Seizures
□ Tremors
□ Weakness
□ Headaches
□ Migraines
□ Numbness
□ Dizziness
□ Loss of Balance
□ Fainting
□ Speech Problems
□ Memory Loss
□ Black Outs
□ Confusion

**Psychiatric**
□ Anxiety
□ Depression
□ Stress
□ Panic Attacks
□ Mood Swings
□ Personality Change
□ Poor Concentration
□ Suicidal
□ Drug/Alcohol Use

**Sleep**
□ Insomnia
□ Excessively Sleepy
□ Sleep Disturbance
□ Snoring
□ Apnea
□ Sleep Walking
□ Sleep Talking
□ Night Terrors

**Males**
□ Impotence
□ Penile Discharge
□ Enlarged Breast
□ Nipple Discharge
□ Breast Lump(s)
□ Infertility
□ Loss of Sex Drive

**Females**
□ Vaginal Discharge
□ Vaginal Dryness
□ Breast Pain
□ Nipple Discharge
□ Breast Lump(s)
□ Irregular Periods
□ Painful Periods
□ Heavy Periods
□ Infertility
□ Hot Flashes
□ Loss of Sex Drive

**Allergies**
_____
_____
_____
_____

## Medications:

Please be certain to include birth control, hormones, and ALL non-prescription medications

| Medication | Dosage | Medication | Dosage |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Preferred Pharmacy_____ Phone_____
Address_____ City _____ State _____ Zip _____

_____ _____
**Signature of Patient or Guardian** **Date**

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# Patient History

Date_____ **Patient Status**: □ New □ Established □ Consultation □ Referral Date of Birth_____

Patient Name (Last)_____ (First)_____ (MI)_____ Sex_____

## Past Medical History:

Date of Last Physical?_____ Abnormalities? □ No □ Yes Explain_____

**Gastrointestinal**
□ NONE
□ Heartburn
□ Reflux Symptoms
□ Gallstones
□ Ulcerative Colitis
□ Anal Fistula
□ Hiatal Hernia
□ Pancreatitis
□ Crohn's Disease
□ Stool Incontinence
□ Gastritis
□ Irritable Bowel (185)
□ Colon Polyps
□ Abnormal Liver Tests
□ H. Pylori
□ Spastic Colitis
□ Colon Cancer
□ Fatty Liver
□ Ulcer
□ Lactose Intolerance
□ Hemorrhoids
□ Hepatitis
□ Celiac Disease
□ Diverticulosis
□ Diverticulitis
□ Anal Fissure
□ Cirrhosis

**Cardiovascular**
□ NONE
□ High Blood Pressure
□ Heart Attack
□ PVCs
□ Mitrai Valve Prolapse
□ High Cholesterol
□ Atrial Fibrillation
□ Rhythm Disorder
□ Rheumatic Fever
□ Angina
□ Tachycardia
□ Heart Murmur
□ Congestive Heart Failure

**Pulmonary**
□ NONE
□ Sleep Apnea
□ Emphysema (COPD)
□ Pulmonary Embolism
□ Lung Cancer
□ Asthma
□ Pneumonia
□ Sarcoidosis
□ Pleurisy

**Neuropsychiatric**
□ NONE
□ Stroke
□ Migraines
□ Dementia
□ Alzheimer's
□ Eating Disorder
□ TIA (Mini Stroke)
□ Chronic Headaches
□ Depression
□ ADHD
□ Multiple Sclerosis
□ Parkinson's Disease
□ Anxiety Hormonal Mood
□ Seizures
□ Myasthenia Gravis
□ Bipolar Disorder
□ Panic Disorder

**Hematologic**
□ NONE
□ Anemia
□ Blood Clot(s)
□ Hodgkin's Disease
□ Leukemia
□ Blood Transfusion
□ Hemochromatosis
□ Lymphoma
□ Myelodysplasia

**Endocrine**
□ NONE
□ Diabetes
□ Hyperthyroidism
□ Goiter
□ Pituitary Problem
□ Hypothyroidism
□ Thyroid Nodule
□ Thyroid Cancer
□ Adrenal Problem

**Genitourinary**
□ NONE
□ Kidney Disease
□ Urinary Tract Infections
□ Ovarian Cyst(s)
□ Kidney Stones
□ Bladder Incontinence
□ Ovarian Cancer
□ Cone Biopsy/Leep
□ Kidney Tumors
□ Kidney Cysts
□ Kidney Cancer
□ Prostate Hypertrophy
□ Uterine Fibroids
□ Cervical Cancer
□ Bladder Cancer
□ Prostate Cancer
□ Uterine Cancer
□ Endometriosis

**Breast**
□ NONE
□ Fibrocystic Breast Disease
□ Breast Cancer (L or R)
□ Radiation
□ Chemotherapy

**Musculoskeletal**
□ NONE
□ Osteoarthritis
□ Osteoporosis
□ Fibromyalgia
□ Lupus
□ Rheumatoid Arthritis
□ Osteopenia
□ Polymyalgia Rheumatic
□ Gout

**Eyes, Ears, Nose & Throat**
□ NONE
□ Glaucoma
□ Macular Degeneration
□ Allergic Rhinitis
□ Oral Thrush
□ Cataracts
□ Retinal Detachment
□ Sinusitis
□ Sjogren's (Dry Eyes)

**Dermatologic**
□ NONE
□ Eczema
□ Vitiligo
□ Raynaud's Syndrome
□ Squamous Cell Skin Cancer
□ Psoriasis
□ Alopecia
□ Basal Cell Skin Cancer
□ Melanoma
□ Scleroderm

**Oncologic**
□ NONE
□ Any other malignant tumors not previously mentioned_____
_____
_____

**Infectious Disease**
□ NONE
□ Tuberculosis
□ Hepatitis
□ Gonorrhea
□ Syphilis
□ HIV
□ Other_____
_____
_____

Any other medical conditions not previously mentioned?_____

**Females** Menopaused? □ No □ Yes Age_____ Form of Birth Control?_____

Age at First Period_____ Date of Last Period_____ Every_____ Days, For_____ Days_____

Pregnancies_____ Miscarriages/Abortions_____Living Children_____ Full Term Births_Premature Births_____

Date of Last Pap?_____ Abnormalities? □ No □ Yes Explain_____

Date of Last Breast Exam?_____ Abnormalities? □ No □ Yes Explain_____

## Past Surgeries / Procedures / Treatments

□ NONE
□ Gallbladder
□ Colonoscopy
□ D & C
□ Vasectomy
□ Back Surgery
□ Appendix
□ C-Section
□ Prostate Surgery
□ Foot Surgery
□ Groin Hernia Repair
□ Tubal Ligation
□ Tonsillectomy
□ Stent/Angioplasty
□ Other Hernia Repair
□ Total Hysterectomy
□ Sinus Surgery
□ Heart Bypass Surgery
□ Bowel Obstruction
□ Partial Hysterectomy
□ Cataract Surgery
□ Heart Valve Surgery
□ Adhesion Surgery
□ Ovarian Surgery
□ Lasik Eye Surgery
□ Pacemaker
□ Colon Resection
□ Uterine Ablation
□ Pacemaker
□ Other Eye Surgery
□ Defibrillator
□ Hemorrhoid Surgery
□ Benign Breast Biopsy
□ Arthroscopy
□ Carotid Surgery
□ Vein Stripping
□ Anti-Reflux Surgery
□ Kidney Transplant
□ Fistula
□ Catheter
□ Lumpectomy
□ Knee Replacement
□ Vascular Surgery
□ Weight Loss Surgery
□ Mastectomy
□ Hip Replacement

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□ Other surgeries not previously mentioned? _____

**Family History:**

□ NONE □ Colon Polyps □ Crohn's Disease □ Helicobacter Pylori □ Colon/Rectal Cancer □ Stomach Cancer
□ Hepatitis C □ Hepatitis B □ Uterine Cancer □ Celiac Disease □ Hemochromatosis □ Ulcerative Colitis
□ Other

If yes, list family members (i.e. mother, grandmother, sister, aunt) and age at diagnosis of polyps or cancers:

_____
_____
_____

**Father**: Living? □ No □ Yes Age_____ Health_____
Dead? □ No □ Yes At Age_____ Cause of Death_____

**Mother**: Living? □ No □ Yes Age_____ Health_____
Dead? □ No □ Yes At Age_____ Cause of Death_____

**Brothers**? □ No □ Yes No. Living_____ Age(s)_____ Health_____
No. Dead_____ At Age(s)_____ Cause of Death_____

**Sisters**? □ No □ Yes No. Living_____ Age(s)_____ Health_____
No. Dead_____ At Age(s)_____ Cause of Death_____

**Children**? □ No □ Yes No. Living_____ Age(s)_____ Health_____
No. Dead_____ At Age(s)_____ Cause of Death_____

**Social History:**

**Marital Status** □ Single/Never Been Married
□ Married How Long_____ Spouse Age_____ Health_____
□ Separated How Long_____
□ Divorced How Long_____
□ Widowed How Long_____ Died At Age_____ Cause of Death_____

**Tobacco Use** □ Never □ Ex-User When quit?_____ □ Current Amount per day?_____ How Long?_____

**Alcohol Use** □ Never □ Occasional □ Social □ Frequent Amount per day?_____ How Long?_____

Problems with Alcohol or Drug use? □ No □ Yes Explain_____

Drink Caffeinated Beverages □ No □ Yes Number of cups per day of: ____Coffee ____Tea ____Soda

Currently Dieting □ No □ Yes How Long?_____ Explain_____

**Occupation** (Or most recent job held)_____

Do you work unusually hard or long hours? □ No □ Yes Explain_____

Is there a lot of tension or pressure in your job? □ No □ Yes Explain_____

Does your job cause you to stress frequently? □ No □ Yes Explain_____

Do you enjoy your job? □ No □ Yes Explain_____

**Other** Is there any other information that is pertinent about your medical history?_____
_____
_____
_____

_____ _____
**Signature of Patient or Guardian** **Date**

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# Authorization To Disclose Protected Health Information

Date_____ Date of Birth_____

Patient Name (Last)_____ (First)_____ (MI)_____ Sex_____

In general, the HIPAA privacy rule gives individuals the right to request uses and disclosures of their protected health information (PHI}. The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home or discussing PHI with family members.

This Standard Authorization gives the doctors and staff of Diagnostic Clinic of Houston your permission to speak to or give written documentation about your medical health information to the person/persons you have designated.

## WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Name_____ Restrictions_____
Relationship_____ Phone #_____

Name_____ Restrictions_____
Relationship_____ Phone #_____

Name_____ Restrictions_____
Relationship_____ Phone #_____

Name_____ Restrictions_____
Relationship_____ Phone #_____

Name_____ Restrictions_____
Relationship_____ Phone #_____

## WHAT INFORMATION CAN BE DISCLOSED?

| | | | |
|---|---|---|---|
| □ All health information | □ History/Physical Exam | □ Past/Present Medications | □ Lab Results |
| □ Physician's Orders | □ Patient Allergies | □ Operation Reports | □ Consultation Reports |
| □ Progress Notes | □ Discharge Summary | □ Diagnostic Test Reports | □ EKG/Cardiology Reports |
| □ Pathology Reports | □ Billing Information | □ Radiology Reports & Images | □ Other |

Your initials are required to release the following information:
_____Mental Health Records (excluding psychotherapy notes) _____Genetic Information (including Genetic Test Results)
_____Drug, Alcohol, or Substance Abuse Records _____HIV/AIDS Test Results/Treatment

**EFFECTIVE TIME PERIOD.** This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month____Day____Year_.

**RIGHT TO REVOKE**. I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

**SIGNATURE AUTHORIZATION.** I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to other covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.506(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

_____ _____
**Signature of Patient or Guardian** **Date**