Welcome to Our Practice

Please fill out the information found below to the best of your ability.

Patient # _____ Physician _____ Date _____

Patient Name _____ Chief complaint _____

History of Present Illness:

Location _____ (Where is the pain/problem?)

Quality _____ (Example: normal versus abnormal color, activity, etc.)

Severity _____ (How severe is the pain/problem on a scale of 1-5 [5 being the most severe]?)

Duration _____ (How long have you had this pain/problem, or when did it start?)

Timing _____ (Does this pain/problem occur at a specific time?)

Context _____ (Where were you at the onset of this pain/problem?)

Associated Signs/ Symptoms _____ (What other associated problems have you been having?)

Modifying Factors _____ (What makes the pain/problem worse or better? Have you had previous episodes?)

Patient Medical History:

Have you ever had the following (check "no" or "yes", leave blank if uncertain):

Measles	☐ No	☐ Yes	Venereal Disease	☐ No	☐ Yes	Blood or Plasma Transfusions	☐ No	☐ Yes	Persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)	☐ No	☐ Yes
Mumps	☐ No	☐ Yes	Anemia	☐ No	☐ Yes	Back Trouble	☐ No	☐ Yes	Mitral Valve Prolapse	☐ No	☐ Yes
Chickenpox	☐ No	☐ Yes	Bladder Infections	☐ No	☐ Yes	High or Low Blood Pressure	☐ No	☐ Yes	Stroke	☐ No	☐ Yes
Whooping Cough	☐ No	☐ Yes	Epilepsy	☐ No	☐ Yes	Hemorrhoids	☐ No	☐ Yes	Hepatitis	☐ No	☐ Yes
Scarlet Fever	☐ No	☐ Yes	Migraine Headaches	☐ No	☐ Yes	Asthma	☐ No	☐ Yes	Ulcer	☐ No	☐ Yes
Diphtheria	☐ No	☐ Yes	Tuberculosis	☐ No	☐ Yes	Hives or Eczema	☐ No	☐ Yes	Kidney Disease	☐ No	☐ Yes
Smallpox	☐ No	☐ Yes	Diabetes	☐ No	☐ Yes	AIDS or HIV+	☐ No	☐ Yes	Thyroid Disease	☐ No	☐ Yes
Pneumonia	☐ No	☐ Yes	Cancer	☐ No	☐ Yes	Infectious Mono	☐ No	☐ Yes	Bleeding Tendency	☐ No	☐ Yes
Rheumatic Fever	☐ No	☐ Yes	Polio	☐ No	☐ Yes	Bronchitis	☐ No	☐ Yes	Any other Disease (Please list) _____	☐ No	☐ Yes
Heart Disease	☐ No	☐ Yes	Glaucoma	☐ No	☐ Yes						
Arthritis	☐ No	☐ Yes	Hernia	☐ No	☐ Yes						

Date of last chest x-ray: _____

Previous Hospitalizations/Surgeries/Serious Illness	When	Hospital, City, State/Prov.

Medications (include nonprescription):

Have you ever taken Fen-Phen/Redux? ☐ No ☐ Yes

Patient Social History:

Marital status:	☐ Single	☐ Married	☐ Separated	☐ Divorced	☐ Widowed
Use of alcohol:	☐ Never	☐ Rarely	☐ Moderate	☐ Daily	
Use of tobacco:	☐ Never	☐ Previously, but quit: _____		☐ Current packs/day _____	
Use of drugs:	☐ Never	☐ Type/frequency: _____			
Excessive exposure at home or work to:	☐ Fumes	☐ Dust	☐ Solvents	☐ Airborne particles	☐ Noise

Family Medical History:

	Age	Diseases	If deceased, cause of death
Father			
Mother			
Siblings			
Spouse			
Children			

Review of Systems: Please indicate any personal history below.

CONSTITUTIONAL SYMPTOMS

Good general health lately	☐ No	☐ Yes
Recent weight change	☐ No	☐ Yes
Fever	☐ No	☐ Yes
Fatigue	☐ No	☐ Yes
Headaches	☐ No	☐ Yes

EYES

Eye disease or injury	☐ No	☐ Yes
Wear glasses/contact lenses	☐ No	☐ Yes
Blurred or double vision	☐ No	☐ Yes

EARS/NOSE/MOUTH/THROAT

Hearing loss or ringing	☐ No	☐ Yes
Earaches or drainage	☐ No	☐ Yes
Chronic sinus problems or rhinitis	☐ No	☐ Yes
Nose bleeds	☐ No	☐ Yes
Mouth sores	☐ No	☐ Yes
Bleeding gums	☐ No	☐ Yes
Bad breath or bad taste	☐ No	☐ Yes
Sore throat or voice change	☐ No	☐ Yes
Swollen glands in neck	☐ No	☐ Yes

CARDIOVASCULAR

Heart trouble	☐ No	☐ Yes
Chest pai or angina pectoris	☐ No	☐ Yes
Palpitation	☐ No	☐ Yes
Shortness of breath walking or lying flat	☐ No	☐ Yes
Swelling of feet, ankles or hands	☐ No	☐ Yes

RESPIRATORY

Chronic or frequent coughs	☐ No	☐ Yes
Spitting up blood	☐ No	☐ Yes
Shortness of breath	☐ No	☐ Yes
Wheezing	☐ No	☐ Yes

GASTROINTESTINAL

Loss of appetite	☐ No	☐ Yes
Change in bowel movements	☐ No	☐ Yes
Nausea or vomiting	☐ No	☐ Yes
Frequent diarrhea	☐ No	☐ Yes
Painful bowel movements or constipation	☐ No	☐ Yes
Rectal bleeding or blood in stool	☐ No	☐ Yes
Abdominal pain	☐ No	☐ Yes

GENITOURINARY

Frequent urination	☐ No	☐ Yes
Burning or painful urination	☐ No	☐ Yes
Blood in urine	☐ No	☐ Yes
Change in force or strain when urinating	☐ No	☐ Yes
Incontinence or dribbling	☐ No	☐ Yes
Kidney stones	☐ No	☐ Yes
Sexual difficulty	☐ No	☐ Yes
Male – testicle pain	☐ No	☐ Yes
Female – pain with periods	☐ No	☐ Yes
Female – irregular periods	☐ No	☐ Yes
Female – vaginal discharge	☐ No	☐ Yes

Female – # of pregnancies: _____

Female – # of miscarriages: _____

Female – date of last pap smear: _____

MUSCULOSKELETAL

Joint pain	☐ No	☐ Yes
Joint stiffness or swelling	☐ No	☐ Yes
Weakness of muscles or joints	☐ No	☐ Yes
Muscle pain or cramps	☐ No	☐ Yes
Back pain	☐ No	☐ Yes
Cold extremities	☐ No	☐ Yes
Difficulty in walking	☐ No	☐ Yes

INTEGUMENTARY (skin, breast)

Rash or itching	☐ No	☐ Yes
Change in skin color	☐ No	☐ Yes
Change in hair or nails	☐ No	☐ Yes
Varicose veins	☐ No	☐ Yes
Breast pain	☐ No	☐ Yes
Breast lump	☐ No	☐ Yes
Breast discharge	☐ No	☐ Yes

NEUROLOGICAL

Frequent or recurring headaches	☐ No	☐ Yes
Light headed or dizzy	☐ No	☐ Yes
Convulsions or seizures	☐ No	☐ Yes
Numbness or tingling sensations	☐ No	☐ Yes
Tremors	☐ No	☐ Yes
Paralysis	☐ No	☐ Yes
Head injury	☐ No	☐ Yes

PSYCHIATRIC

Memory loss or confusion	☐ No	☐ Yes
Nervousness	☐ No	☐ Yes
Depression	☐ No	☐ Yes
Insomnia	☐ No	☐ Yes

ENDOCRINE

Glandular or hormone problems	☐ No	☐ Yes
Excessive thirst or urination	☐ No	☐ Yes
Heat or cold intolerance	☐ No	☐ Yes
Skin becoming dryer	☐ No	☐ Yes
Change in hat or glove size	☐ No	☐ Yes

HEMATOLOGIC/LYMPHATIC

Slow to heal after cuts	☐ No	☐ Yes
Bleeding or bruising tendency	☐ No	☐ Yes
Anemia	☐ No	☐ Yes
Phlebitis	☐ No	☐ Yes
Past transfusion	☐ No	☐ Yes
Enlarged glands	☐ No	☐ Yes

ALLERGIC/IMMUNOLOGIC

History of skin reaction or other adverse reaction to:

Penicillin or other antibiotics	☐ No	☐ Yes
Morphine, Demerol, or other narctotics	☐ No	☐ Yes
Novocain or other anesthetics	☐ No	☐ Yes
Aspirin or other pain remedies	☐ No	☐ Yes
Tetanus antitoxin or other serums	☐ No	☐ Yes
Iodine, merthiolate or other antiseptics	☐ No	☐ Yes

Other drugs/medications: _____

_____

_____

_____

_____

Known food allergies: _____

_____

_____

_____

Environmental allergies: _____

_____

_____

_____

AUTHORIZATION & RELEASE

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

X _____ _____

Signature of patient (or parent/guardian if minor) Date

Doctor's Review: _____

_____

_____

_____

_____

_____

_____

_____

Signature of Doctor Date

Patrick L. Allen, M.D., P.A.
Gynecology
7560 Glenview Drive, Suite 106, Richland Hills, TX 76180 / Phone (817) 590-8700

Personal Information

Date: _____

Last Name: _____ First Name: _____ MI: _____

Nickname _____ Social Security# _____ Date of Birth _____

Address _____ Apt# _____ City _____

State _____ Zip Code _____ ***Sex:*** Female Male

Preferred Way of being called

Phone 1st # _____ Home/Cell/Work

Phone 2nd # _____ Home/Cell/Work

Phone 3rd # _____ Home/Cell/Work

Email _____

Name of Employer _____ Occupation _____

Marital Status: Single Married Divorced Widowed Legally Separated Partner

Name of pharmacy _____ Phone# _____ Fax# _____

In the event of an emergency, who should we contact? _____

Relationship _____ Phone# _____

Referred By _____

Primary Holder of Insurance Policy: Self Parent Spouse Other

Secondary Holder of Insurance Policy: Parent Spouse Other

Patrick L. Allen, M.D., P.A.
Gynecology
7560 Glenview Drive, Suite 106, Richland Hills, TX 76180 / Phone (817) 590-8700

Insurance Information

Primary Insurance
(If other than self)

Last Name: _____ First Name: _____ MI: ____

Social Security# _____ Date of Birth_____

Address _____ Apt# _____ City _____

State_____ Zip Code _____ ***Sex:*** Female Male

Home #_____ Mobile#_____

Work# _____ Ext# ____ Email _____

Name of Employer _____ Occupation _____

Primary Holder of Insurance Policy: Parent Spouse Other

Secondary Insurance

Last Name: _____ First Name: _____ MI: ____

Social Security# _____ Date of Birth_____

Address _____ Apt# _____ City _____

State_____ Zip Code _____ ***Sex:*** Female Male

Home #_____ Mobile#_____

Work# _____ Ext# ____ Email _____

Name of Employer _____ Occupation _____

Secondary Holder of Insurance Policy: Parent Spouse Other