FRANK P. JIRCIK, M.D.
Precious Marquart, M.D.
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BURLESON TX 76028
PH: 817-551-5400 FAX: 817-568-0961

DATE _____

PATIENT NAME _____
LAST FIRST MI

ADDRESS _____

CITY _____ TX _____ ZIP _____

SOCIAL SECURITY# _____ DATE OF BITH _____ SEX – M____ F____

MARITAL STATUS – SINGLE_____ MARRIED _____ DIVORCED_____ SEPARATED _____ WIDOW _____

HOME PHONE _____ CELL PHONE _____

EMAIL _____

REFERRED BY _____

PATIENT AUTHORIZATION FOR COMMUNICATION VIA ALTERNATIVE MEANS. I AUTHORIZE DR. FRANK P. JIRCIK AND/OR AARON MITSCHKE, NP TO COMMUNICATE MY PROTECTED HEALTH INFORMATION (PHI) IN THE MANNER INDICATED BELOW. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO NOTIFY THE OFFICE OF ANY CHANGE IN THIS MANNER.

(CHECK THE BOX THAT APPLIES)

PRIMARY# _____ CELL# _____ WORK#_____ U.S MAIL_____ FAX# _____

_____ LEAVE A DETAILED MESSAGE ON MY MACHINE/VOICEMAIL

_____ LEAVE A BRIEF MESSAGE WITH ONLY A CALLBACK NUMBER & DR'S INFORMATION

EMPLOYER _____ ADDRESS _____

PATIENT ETHNICITY _____ HISPANIC/LATINO _____ NOT HISPANIC/LATINO _____

RACE - AMERICAN INDIAN ALASKA NATIVE ASIAN
NATIVE HAWAIIAN OTHER PACIFIC ISLANDER
BLACK/AFRIAN AMERICAN WHITE DECLINE TO ANSWER

NAME OF SPOUSE _____ SPOUSES SS# _____

DATE OF BIRTH _____

EMERGENCY CONTACT _____ RELATIONSHIP _____ _____

PHONE# _____ PREFERRED LANGUAGE _____

LOCAL PHARACY _____ MAIL ORDER PHARMACY_____

PLEASE LIST OR EXPLAIN THE REASON(S) FOR VISIT _____

PATIENT NAME _____ DATE OF BIRTH _____

MEDICAL HISTORY: CHECK CONDITIONS THAT YOU HAVE HAD, OR ARE CURRENTLY HAVING:

_____ AIDS/HIV
_____ ALCOHOLISM
_____ ANEMIA
_____ ARTHRITIS
_____ ASTHMA
_____ BRONCHITIS
_____ CANCER (TYPE) _____
_____ CHEMICAL DEPENDENCY
_____ COPD/EMPHYSEMA
_____ CHEST PAIN/PRESSURE
_____ CATARACTS
_____ DEFIBRILLATOR
_____ DEPRESSION/ANXIETY
_____ DIABETES (TYPE)
_____ DIGESTIVE PROBLEMS
_____ ECZEMA
_____ EPILEPSY /SEIZURES
_____ GLAUCOMA
_____ GOUT
_____ HEART DISEASE
_____ HEPATITIS
_____ HIGH BLOOD PRESSURE
_____ HEADACHES/MIGRAINES
_____ HEMORRHOIDS
_____ HERPES
_____ HERNIA
_____ KIDNEY DISEASE
_____ MEMORY LOSS
_____ PACEMAKER
_____ PROSATE PROBLEMS
_____ PSYCHIATRIC CARE
_____ SEXUALLY TRASMITTED DISEASE
_____ STROKE
_____ THYROID DISORDER
_____ TUBERCULOSIS
_____ ULCERS
_____ URINARY INCONTINENCE
_____ URINARY TRACT INFECTION

ALLERGIES/ADVERSE REACTIONS: _____

SURGICAL HISTORIES – LIST ALL _____

PATIENT NAME _____ DATE OF BIRTH _____

FAMILY HISTORY: _____ CONDITION/CAUSE OF DEATH: _____

FATHER _____ ALIVE _____ DECEASED _____
MOTHER _____ ALIVE _____ DECEASED _____
HOW MANY SIBLINGS? SISTERS _____ BROTHERS _____
HOW MANY CHILDREN? _____

DOES A FAMILY MEMBER HAVE ONE OF THE FOLLOWING?

	FATHER	MOTHER	FATHER'S FAMILY	MOTHER'S FAMILY	SIBLINGS	CHILDREN
HYPERTENSION						
EPILEPSY						
CANCER						
ECZEMA/PSORIASIS						
HEART ATTACK						
STROKE						
DIABETES						
ASTHMA						

IMMUNIZATION:

_____ SMALLPOX
_____ TETANUS
_____ TYPHOID
_____ POLIO
_____ INFLUENZA
_____ PNEUMONIA
_____ RUBELLA
_____ HEPATITIS

SOCIAL HISTORY:

_____ TOBACCO: CURRENT SMOKER_____ FORMER SMOKER _____ NEVER SMOKED _____
_____ IF YOU ARE A CURRENT SMOKER, HOW OFTEN DO YOU SMOKE CIGARETTES? _____
_____ HOW MANY CIGARETTES A DAY DO YOU SMOKE? _____
_____ FORMER SMOKER, HOW LONG HAS IT BEEN SINCE YOU LAST SMOKED?_____
_____ DO YOU DIP TOBACCO? _____
_____ ALCOHOL: DO YOU DRINK ALCHOLIC BEVERAGES? _____ HOW OFTEN? _____
_____ CAFFIENE: DO YOU DRINK CAFFIENE BEVERAGES? _____WHAT TYPE _____

PATIENT NAME ______________________________ DATE OF BIRTH _______________

Medication Record

DATE	MEDICATION	DOSE GIVEN	FREQUENCY (i.e. 2 X PER DAY)	TIME	AM/PM

Allergy Questionnaire – Intake Questions

Patient Name: _____ Date of Birth: _____

Reviewed By: _____ Date: _____

Do you experience any of these symptoms more than twice per year? Check all that apply)

___ Cough
___ Difficulty breathing
___ Runny nose
___ Sinus pain
___ Skin irritation
___ Cold
___ Headaches
___ Sore throat
___ Ear pain
___ Snoring
___ Congestion
___ Wheezing
___ Itchy/irritated eyes
___ Unexplained fatigue

Have you ever been diagnosed with Asthma or bronchitis?

___ Yes
___ No

Do you experience symptoms of allergies?

___ Yes
___ No