# Patient Registration

First Name_____ Middle_____ Last _____

Address _____

City _____ State _____ Zip _____

Date of Birth _____ Age _____Sex _____ SS# _____

Phone # (_____) _____-_____ Cell # (_____) _____-_____

Email _____

Race _____ Ethnicity **(Circle One)** Hispanic / Non Hispanic

Preferred Language _____

Employed by _____

Work # _____Ext._____

Preferred Pharmacy _____

Drug Allergies _____

Single_____ Married_____ Widowed _____ Divorced _____

Name of Spouse _____

Date of birth_____ SS# _____

Employed by _____

Work # _____ Cell # _____

Children

_____ Age _____

_____ Age _____

_____ Age _____

Medicare # _____

**OR**

Primary Insurance _____

Insured's Name _____

Insured's Date of Birth _____SS#_____

Policy # _____ Group # _____

Secondary Insurance _____

Insured's Name _____

Insured's Date of Birth _____SS#_____

Policy # _____ Group # _____

Emergency Contact Name/# _____

**Assignment of Benefits**

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled including Medicare, private insurance, and any other plan to Aaron C. Polk, Jr., M.D. and/or Carl A. Davis, M.D. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment and to request a review of claim.

Signed _____ Date _____

## Family History

| Relative | Disease | Age |
|---|---|---|
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## Place A Check For Any Condition Which Applies To A Blood Relative

| | Condition | Who |
|---|---|---|
| ☐ | Alcohol/Drug Abuse | |
| ☐ | Allergies/Asthma | |
| ☐ | Arthritis/Gout | |
| ☐ | Bleeding Disorder | |
| ☐ | Cancer Type | |
| | | |
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| | | |
| | | |
| ☐ | Diabetes | |
| ☐ | Epilepsy/Seizures | |
| ☐ | Glaucoma | |
| ☐ | Heart Disease | |
| ☐ | High Blood Pressure | |
| ☐ | High Cholesterol | |
| ☐ | HIV/AIDS | |
| ☐ | Kidney/Disease | |
| ☐ | Mental Illness | |
| ☐ | Migraine Headaches | |
| ☐ | Sickle Cell Condition | |
| ☐ | Stroke | |
| ☐ | Suicide/Depression | |
| ☐ | Thyroid Disease | |
| ☐ | Other | |
| | | |
| | | |

The most interesting thing about me is _____

_____

_____

_____

_____

_____

Patient Signature:_____

## Immunization History

| Have you had: | | | Date |
|---|---|---|---|
| Chicken pox or Shot | ☐ Yes | ☐ No | |
| Hepatitis B Series or Shot | ☐ Yes | ☐ No | |
| Influenza Shot | ☐ Yes | ☐ No | |
| Pneumonia Shot | ☐ Yes | ☐ No | |
| Rubella Shot or Blood Test | ☐ Yes | ☐ No | |
| Tetanus Shot | ☐ Yes | ☐ No | |

**Questions for Women Only:**

**Menstration:**

Age Periods Began: _____

How Often: _____

Last Menstrual Period: _____

PMS Symptoms: ☐ Yes ☐ No

Birth control ☐ Yes ☐ No

**Pregnancies:**

Total number: _____ Full Term: _____

Premature: _____ Miscarriages: _____

Abortions: _____ Tubal Pregnancies: _____

Complications: _____

**Diet, Exercise, & Habits:**

Do you follow a special diet? _____

Weight? Current _____Desired_____ 1 yr ago_____

What kind of exercise do you do and how often?

_____

_____

**Tobacco Use:**

Do you smoke? ☐ Yes ☐ No

If yes, what type? _____

Have you quit smoking? ☐ Yes ☐ No

Do you use other tobacco products? ☐ Yes ☐ No

If yes, what type? _____

How much? _____

**Alcohol Use:**

Do you drink alcohol? ☐ Yes ☐ No

If yes, what type? _____

Has anyone ever expressed concerns about your alcohol use? ☐ Yes ☐ No

If yes, please explain: _____

_____

_____

Religious Affiliation: _____

Highest Education achieved?_____

Previous jobs? _____

Exposure to hazardous conditions/substances at work?

_____

Do you have a living will? ☐ Yes ☐ No

Are you an organ donor? ☐ Yes ☐ No

Physican Signature: _____

# Confidential Health History Questionnaire - Past Medical History

Name: _____ Nickname: _____

Date of Birth: _____ Date: _____

## Allergies

None ☐

(List any allergies to medicines or other substances)

## Surgeries

DATE Reason None ☐

## Illnesses

None ☐

(List any chronic or recurrent illnesses - date of onset)

## Accidents/injuries

DATE (please list) None ☐

## List All Medications You Take Regularly Prescription and Non-prescription

Medicine Dose None ☐

## Reason for Today's visit

☑ **Please check any that you have had or now have:**

- ☐ Abnormal Pap Smear
- ☐ AIDS or HIV Disease
- ☐ Alcohol Overuse or Abuse
- ☐ Allergies or Hay Fever
- ☐ Anemia (i.e. -low iron)
- ☐ Anxiety or Panic Attacks
- ☐ Arthritis or Gout
- ☐ Asthma
- ☐ Back Problems
- ☐ Bladder infections
- ☐ Blood Clots or Bleeding Prob.
- ☐ Blood Transfusion
- ☐ Boils or Cysts- recurrent
- ☐ Bone or Joint Disease
- ☐ Bowel or Colon Disease
- ☐ Broken or cracked bones
- ☐ Breast Lumps
- ☐ Bronchitis - recurrent
- ☐ Bursitis or Tendonitis
- ☐ Cancer
- ☐ Cholesterol - elevated
- ☐ Colitis
- ☐ Concussion or Head Injury
- ☐ Depression
- ☐ Suicide Attempt
- ☐ Diabetes
- ☐ Drug Overuse or Abuse
- ☐ Emphysema
- ☐ Excessive Stress
- ☐ Gallbladder Disease or Gallstone
- ☐ Glaucoma
- ☐ Gonorrhea, Syphilis, Chlamydia, or HPV
- ☐ Headaches - Severe
- ☐ Hearing Problem
- ☐ Heart Attack
- ☐ Heart Murmur or Heart Disease
- ☐ Hepatitis or Cirrhosis
- ☐ Herniated or Ruptured Disc
- ☐ Herpes - genital
- ☐ High Blood Pressure
- ☐ Hodgkin's Disease, Lymphoma or Leukemia
- ☐ Irritable Bowel Syndrome
- ☐ Kidney Stones
- ☐ Liver Problems
- ☐ Lupus
- ☐ Malaria
- ☐ Meningitis
- ☐ Migraine Headache
- ☐ Muscle Disease or Weakness
- ☐ Nervous Breakdown
- ☐ Pancreatitis
- ☐ Phlebitis
- ☐ Pleurisy
- ☐ Pneumonia
- ☐ Polio
- ☐ *Rheumatoid* Arthritis
- ☐ Rheumatoid Fever
- ☐ Seizures, Convulsions, or Epilepsy
- ☐ Sexually Transmitted Disease
- ☐ Sickle Cell Disease or Trait
- ☐ Skin Disease - Chronic
- ☐ Skin Infections - Recurrent
- ☐ Sleep Difficulties or Disorders
- ☐ Sprains or Dislocations - Severe
- ☐ Stroke or Brain Attack
- ☐ Thyroid Disease
- ☐ Tuberculosis (TB) or positive test
- ☐ Ulcer Disease or Gastritis
- ☐ Varicose Veins
- ☐ Venereal Disease
- ☐ Vision Problem
- ☐ Yellow jaundice
- ☐ **Other**

# Symptom Survey

Patient Name:_____ Date:_____

**Scale of Symptom Points:**

0 = Do not suffer from this ever or almost ever
1 = Suffer OCCASIONALLY (>2 times per week), not severe
2= Suffer FREQUENTLY (2+ times per week), not severe
3= Suffer OCCASIONALLY, severe
4= Suffer FREQUENTLY, severe

### *Emotional/Mental*

0 1 2 3 4 Depression (feelings of hopelessness)
0 1 2 3 4 Anxiety (vague fears, uneasiness)
0 1 2 3 4 Mood swings (rapid distinct changes)
0 1 2 3 4 Irritability

### *Cardiovascular*

0 1 2 3 4 Irregular heartbeat
0 1 2 3 4 High blood pressure
0 1 2 3 4 Chest pain
0 1 2 3 4 Palpitations
0 1 2 3 4 Chest heaviness
0 1 2 3 4 Tightness

### *Constitutional*

0 1 2 3 4 Fatigue (sluggish)
0 1 2 3 4 Hyperactive
0 1 2 3 4 Restless (can't sit still)
0 1 2 3 4 Sleepiness during day
0 1 2 3 4 Insomnia at night
_____ Record actual weight
_____ Record actual height
0 1 2 3 4 Binge eating or drinking
0 1 2 3 4 Purging (all methods)
0 1 2 3 4 Water retention

### *Neurological*

0 1 2 3 4 Tremors
0 1 2 3 4 Speech problems
0 1 2 3 4 New localized weakness
0 1 2 3 4 Numbness or tingling
0 1 2 3 4 Clumsiness
0 1 2 3 4 Headache

### *Urological*

0 1 2 3 4 Leakage/incontinence
0 1 2 3 4 Daytime frequency
0 1 2 3 4 Nighttime frequency
0 1 2 3 4 Pain with urination
0 1 2 3 4 Blood in urine
0 1 2 3 4 Difficulty emptying
0 1 2 3 4 Prostate trouble (men only)

### *Digestive*

0 1 2 3 4 Heartburn/esoph.reflux
0 1 2 3 4 Stomach pains/cramps
0 1 2 3 4 Intestinal pains/cramps
0 1 2 3 4 Constipation
0 1 2 3 4 Diarrhea
0 1 2 3 4 Bloating sensation
0 1 2 3 4 Gas (of any kind)
0 1 2 3 4 Nausea, vomiting
0 1 2 3 4 Painful elimination
0 1 2 3 4 Rectal bleeding

### *Skin*

0 1 2 3 4 Sores/lesions
0 1 2 3 4 Rashes, hives
0 1 2 3 4 Eczema
0 1 2 3 4 "Rosy" cheeks
0 1 2 3 4 Acne

### *Nasal/Sinus*

0 1 2 3 4 Congestion
0 1 2 3 4 Sinus pain
0 1 2 3 4 Runny nose
0 1 2 3 4 Sneezing

### *Ears*

0 1 2 3 4 Earache
0 1 2 3 4 Ear infection
0 1 2 3 4 Ringing in ear
0 1 2 3 4 Itchy ears
0 1 2 3 4 Ear discharge

### *Musculoskeletal*

0 1 2 3 4 Joint Pains
0 1 2 3 4 Stiff Joints
0 1 2 3 4 Muscle Aches
0 1 2 3 4 Arthritis

### *Vision*

0 1 2 3 4 Vision loss
0 1 2 3 4 Blurred vision

**1. Please circle the following symptoms (if any) that you have experienced in the past 60 days.**

dizziness lightheadedness "weak spells" fainting visual changes

"pounding in chest" fluttering or flip flop indigestion-like pain sensations of choking

2. Have any of your immediate family members had heart disease? yes no
3. Have any of your immediate family members had diabetes? yes no
4. Have you recently stopped or started smoking? yes no
5. Have you recently started an exercise program? yes no

Patient Signature:_____

Doctor Signature:_____

**Aaron C. Polk, Jr., M.D.**
**Carl A. Davis, M.D.**
**212 Russell Blvd.**
**Nacogdoches, TX 75965**

ACKNOWLEDGEMENT OF REVIEW OF
NOTICE OF PRIVACY PRACTICES

I have reviewed this office's Notices of Privacy Practices, which explains how my medical information will be used and disclosed. I have been given an opportunity to ask questions if I do not understand.

I understand that I am entitled to receive a copy of this document.

_____
Initial

PHARMACY QUERY PERMISSION

By signing below, I give the offices of Dr. Aaron C. Polk, Jr. and Dr. Carl A. Davis permission to query all medications prescribed to me from the online pharmacy database.

_____
Initial

_____
Signature of Patient or Personal Representative

_____ _____
Printed Name of Patient Date of Birth

_____
Date