NEW PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____ Date: _____

Age: _____ Male ❑ Female ❑ Driver's License #: _____ Social Security #: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____)_____ Cell Phone: (_____)_____

Employer: _____ Work Phone: (_____)_____

Referred By: _____ Primary Care Doctor: _____

Email Address: _____

IF CHILD: Legal Guardian Name(s): _____

Do you wish to receive email notifications about appointments and/or access to our patient portal: ❑ Yes ❑ No

FINANCIAL RESPONSIBILITY (*billing statements)*

Circle one: Same as Patient Different than Patient ***(If different, fill out this section)***

Name: _____ Relationship to Patient: _____

Address: _____Phone: (_____)_____

Date of Birth:_____ SS#:_____

EMERGENCY CONTACT

Name: _____ Relationship to Patient: _____

Address: _____ Phone: (_____)_____

HOW DID YOU HEAR ABOUT US?

❑ Doctor: _____ ❑ Other

❑ Friend ❑ Internet /Website

❑ Ad (*which publication?):* _____ ❑ Radio

Other Family Members Who Are HCI Patients? ❑ Yes ❑ No

Patient Name: _____ Date of Birth: _____ Date: _____

ACKNOWLEDGEMENTS/CONSENTS *(please initial on the line next to each section after reading)*

_____ **Receipt of *Notice of Privacy Practices***

I, *(print patient or guardian name)*_____, have read a copy of Hill Country Infusion's *Notice of Privacy Practices.* (This document is available at our front desk or HillCountryInfusion.com)

_____ **Cancellation Policy**

If the patient cannot adhere to a scheduled appointment, it is the patient's responsibility to call the office to cancel within 24 hours of the scheduled appointment. Hill Country Infusion reserves the right to charge the patient a $50 fee if the patient does not cancel the appointment within 24 hours.

_____ **Release of Medical Information**

I **do / do not** *(circle one)* authorize Hill Country Infusion and its designated representatives to release medical information to my spouse, parent, or guardian.

_____ **Contact Permission**

In the event that Hill Country Infusion needs to contact you (patient) regarding an appointment, lab result, medication, or any other reason, it is permissible to *(check all that apply)*:

- ❑ Leave a message on an answering machine.
- ❑ Speak with spouse / significant other. (Name:_____)
- ❑ Speak with other family members. (Name(s):_____)

_____ **Consent to Treatment**

I consent to the performance of those diagnostic procedures, examinations, and rendering of treatment by the medical provider and their designated office staff as is deemed necessary in the medical provider's judgement.

_____ **Authorization / Assignment / Financial Responsibility**

I authorize the release of any medical information necessary to collect payments. I understand that I am financially responsible for all charges. Should my account become a collection problem, additional charges may be incurred.

My signature below indicates that I have read and am in agreement with all statements that I have initialed above.

_____ _____

Signature of Patient (or Person Authorized) Date

Patient Name: _____ Date of Birth: _____ Date: _____

MAIN REASON(S) FOR TODAY'S VISIT

What is the main reason(s) for today's visit? _____

_____

When was the first time you had this problem? _____

When did this episode start? _____ How often do episodes recur? _____

What time of day are symptoms worse? *(circle)* morning noon afternoon nighttime all the time anytime

During which months is it most severe? *(circle)* Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec all year

Are symptoms worse in certain locations? *(circle)* home work outside indoors other _____

Suspected causes: *(circle)* trees weeds grass mold dust perfumes scents heat cold weather changes

smoke stress cats dogs other animals_____ foods_____ other_____

How long have you lived in this area? _____ Moved from where? _____

Where did you grow up? _____

REVIEW OF SYMPTOMS *(Circle any current symptom(s)/description(s) that applies or circle "NS" if you have no symptoms)*

General healthy fever chills night sweats body aches fatigue malaise weight loss weight gain

Nose NS congestion decreased sense of smell post nasal drip nasal discharge (runny/thick/clear/discolored) sneezing snorting rubbing bleeds

Sinus NS infections (past/constant/frequent/occasional) pressure drainage

Ears NS infections (past/constant/frequent/occasional) pressure popping discharge earache hearing loss

Eyes NS itchy watery red burning dry swollen eyelids puffy dark circles under eyes

Mouth NS bad breath gum problems lip swelling pain in teeth grinding itching ulcers tongue swelling

Throat NS difficulty swallowing sore clearing snoring hoarseness loss of voice post nasal drip swelling

GI NS heartburn vomiting nausea diarrhea constipation cramping bloating

Chest NS tightness pain palpitations heaviness pressure congestion cramping bloating

Wheezing NS daily frequent occasional rare associated with illness/exercise

Coughing NS constant/frequent/occasional dry deep hacking gasping turning blue productive of mucus

Shortness of Breath NS constant/frequent/occasional nighttime with exercise with normal activity at rest

Urinary NS frequency urgency burning pain difficulty urinating

Joints NS swollen painful

Skin NS itching dry rash hives blistering swelling

Neuro NS dizziness lightheaded sleep disturbance anxiety depressed passing out numbness tremor

Headache NS

Frequency: constant frequent occasional rare

Severity: incapacitating severe moderate minor

Nature: throbbing dull stabbing

Location: L/R sided top/back of head between/behind eyes temples forehead

Symptoms: sound sensitivity light sensitivity nausea vomiting visual changes pain in teeth

Patient Name: _____ Date of Birth: _____ Date: _____

MEDICATION/MEDICAL HISTORY

1. Current Medications *(prescription, non-prescription, herbal, vitamins, creams, sprays, pills, liquids, drops):*

   1._____ 4._____ 7._____

   2._____ 5._____ 8._____

   3._____ 6._____ 9._____

2. Have you ever been prescribed an **EpiPen** (adrenalin/epinephrine)? Y☐ N☐ If yes, for:_____
3. What medications have been HELPFUL now or in the past? _____
4. What medications have been UNHELPFUL? _____
5. Drug Allergy/Intolerance: *Describe when/what reaction occurred or (circle)* ***None Known****:*

   1._____ _____

   2._____ _____

   3._____ _____

6. Your preferred pharmacy and location? _____
7. Hospitalizations / Surgical Operations (include dates):

   1._____ 4. _____

   2. _____ 5. _____

   3. _____ 6. _____

8. Other problems? *(please circle any that you have now or have had in the past)*

High blood pressure	Reflux	Thyroid problems	Heart attack
Hiatal hernia	Kidney problems	Stroke	Diabetes
Chronic infections	Glaucoma	Emphysema	Skin problems
Cataracts	History of asthma	Lupus/other Autoimmune	Depression
Gout	Liver problems	Bipolar	Arthritis
Cancer of _____	ADD/ADHD	Fibromyalgia	Bleeding problems
Osteoporosis/osteopenia	HIV	Hepatitis A, B or C	HSV
Tuberculosis	Other:_____		

ENVIRONMENTAL / SOCIAL HISTORY

1. Occupation / grade in school / daycare _____
2. Hobbies: _____
3. **IF CHILD:** full term premature *(how early?)*_____ birth weight_____ Delivery: vaginal☐caesarean☐ adopted☐

   Complications: before during after birth? Y☐N☐If yes, what? _____

   Who has legal custody?_____ With whom does child live?_____

Patient Name: _____ Date of Birth: _____ Date: _____

4. Vaccinations current? Y N **Flu vaccine :** Yr:_____Mo:_____ **Pneumococcal vaccine** *(65 or older)* Yr:_____Mo:_____
5. Personal tobacco use (cigarette/chew/pipe/snuff/e-cig): Never ☐ Former ☐ Current ☐

   If yes, how many years?_____ frequency? Some Days or Every Day packs per day?_____
6. Alcohol use: How often in the last year have you had a drink *(circle one)*: Never ≤Monthly 2-4/Month 2-3/Week ≥4/Week

   When drinking, typical # of drinks per day *(circle one)*: 1-2 3-4 5-6 7-9 ≥10

   # of times in the past year ≥6 drinks per day *(circle one)*: Never Less than Monthly Monthly Weekly Daily
7. Recreational drug use: Never☐ Former☐ Current☐ If yes, what? _____
8. Any increased **HIV** or **HSV** risk factors? Y☐ N☐ Not Sure ☐
9. Pets (type/number)_____ how long?_____

   Where do they stay? inside☐ outside☐ both☐in bedroom☐Do you have increased allergy symptoms around animals? Y☐ N☐
10. Home: Age of building_____ water damage/leaks ☐ visible mold/musty odor☐

    Please circle appropriate responses below:

    Flooring: carpet tile hardwood throw rugs other_____

    Bedroom: box spring/mattress waterbed stuffed chair/couch throw pillows down pillows and/or comforter tapestries

    Window coverings: cloth roll shades shutters wood/metal/plastic blinds

    Fans: not used yes, in rooms

    Air conditioning: central window units
11. Workplace/Home/School Exposure: mold animals chemicals metals paint fumes smoke other_____

INFLAMMATION HISTORY

1. Have you ever been tested for allergies/Inflamation? Y☐ N☐ ***(If "no", please skip to question 7 in this section)***
2. Describe the nature of the inflammatory symptoms you have _____

   _____
3. What kind of work up have you had before? _____
4. Where can we obtain your test results? _____
5. What working diagnoses were you given? _____
6. Did you get any specific treatments? Y☐ N☐ If yes, how long ago and what kinds of treatments? _____

   _____
7. Food & Chemical allergy/intolerance: D*escribe when/what reaction occurred or (circle)* ***None Known****:*

   1._____ _____

   2._____ _____

   3._____ _____