YOUR FAMILY MEDICAL
KEEPING YOUR FAMILY WELL

NEW PATIENT INFORMATION

☐ Bedford
☐ Lewisville
☐ Benbrook
☐ Justin
☐ Boyd

Even though we at Your Family Medical (YFM) are committed to compassionate care, we must exercise proper due diligence when prescribing opioid analgesics for chronic pain. Prescription drug abuse has reached epidemic proportions in our society. Therefore, our clinic policy is that an appropriate workup must be completed prior to the dispensing of an opioid prescription. This workup will include review of previous pharmacy/clinic records, evaluation by diagnostic and laboratory tests, and acceptable completion of a urine drug screen yielding expected results. Common examples of opioid analgesics include hydrocodone, morphine, oxycodone, fentanyl, Opana, and methadone.

- Please bring your driver's license and insurance cards along with your completed new patient paperwork to your scheduled appointment. Payment for services are expected at the time of service (co-pays, co-insurance, private pay). We accept cash and credit cards (Visa, American Express, MasterCard, and Discover).
- **If you have been instructed to obtain imaging reports and/or films by our staff, please bring them to your appointment. Our office requires these as part of your consultation.** ***If we do not have your films at the time of your appointment, you may be rescheduled.***
- NO CHILDREN are allowed in the clinic. Many of our patients are in wheelchairs and walkers and we see too many people to have children in the clinic. You will not be seen if you bring your children.
- If English is your second language, in order to provide you with the best health care service, please make arrangements for someone to accompany you to your visit who can translate. We want you to fully understand your diagnosis and prognosis and to answer any questions you may have.

Your Appointment is: _____

****If you have not filled out or completed the New Patient Packet, please arrive 30 minutes prior to your appointment.**

We wish to make your visit as comfortable as possible, so please do not hesitate to contact us if you have any questions or concerns.

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NAME:_____ Date of Birth:_____ DATE:_____

Is this your legal name? ☐Yes ☐No

If no, LEGAL NAME: _____ FORMER NAME(S)? _____

_____ _____

NEW PATIENT INTAKE

Patient's Age _____ Gender: M ☐ F ☐

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____ WORK PHONE: _____

SSN: _____ DRIVER'S LICENSE #: _____

MARITAL STATUS: ☐ Married ☐ Widowed ☐ Single ☐ Divorced

ETHNICITY: ☐ Hispanic or Latino ☐ Not Hispanic or Latino PREFERRED LANGUAGE: _____

RACE: ☐Native American ☐Asian ☐Black/African-American ☐Native Hawaiian/Other Pacific Islander ☐White ☐Other

RELIGION: _____ EDUCATION: _____

E-MAIL: _____☐@yahoo.com ☐@gmail.com ☐@hotmail.com

PREFERRED METHOD OF COMMUNICATION: ☐Home phone ☐Cell phone ☐Work Phone ☐E-mail

REFERRING PHYSICIAN: _____ PRIMARY CARE PHYSICIAN: _____

OTHER PHYSICIANS: _____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____

EMERGENCY PHONE: _____ PHONE TYPE: _____

RESPONSIBLE PARTY INFORMATION

NAME: _____ DATE OF BIRTH:_____

ADDRESS:_____

RELATIONSHIP: _____ PHONE: _____ SSN: _____

EMPLOYER: _____ EMPLOYER PHONE:_____

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NAME:_____ Date of Birth:_____ DATE:_____

INSURANCE INFORMATION

INSURANCE COMPANY: _____ **(Provide card to front desk)**

INSURED'S NAME:_____ DATE OF BIRTH:_____

INSURED'S SSN: _____

RELATIONSHIP TO PATIENT ☐Self ☐Spouse ☐Dependent

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Your Family Medical or insurance company to release any information required to process my claims.

Patient/Guardian Signature _____ Date _____

PAST MEDICAL HISTORY

Please indicate if you have suffered from any of the following medical conditions. ***Also note the year these occurred.***

_____AIDS or HIV
_____Arthritis
_____Asthma
_____Cancer
_____Chronic skin disease
_____Depression
_____Diabetes
_____Emphysema
_____Fibromyalgia
_____Gallbladder
_____Gonorrhea
_____Gout
_____Headaches/migraine
_____Heart disease/attack
_____Heart failure
_____Heart murmur
_____Hepatitis
_____Herpes infection
_____High blood pressure
_____Hormone problems
_____Insomnia
_____Irregular heart beat
_____Jaundice
_____Kidney disease
_____Kidney Stones
_____Liver disease
_____Lupus
_____Menopause
_____Multiple sclerosis
_____Nervous breakdown
_____Other blood abnormality
_____Other venereal disease
_____Panic attacks
_____Peptic ulcer disease
_____Peripheral vascular disease
_____Pneumonia
_____Prostate enlargement
_____Rheumatic heart
_____Schizophrenia/bipolar
_____Seizures/convulsions
_____Shingles
_____Stroke
_____Syphilis
_____Thyroid
_____Tuberculosis
_____Urinary infection

Other: _____
_____
_____
_____

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PAST SURGICAL HISTORY

_____Date/Year_____ _____Date/Year_____

_____Date/Year_____ _____Date/Year_____

_____Date/Year_____ _____Date/Year_____

FAMILY HISTORY

List any disease, illness, or ailments in your IMMEDIATE FAMILY. (i.e. mother-breast cancer, father - diabetic, grandfather - heart disease)

_____

_____

SOCIAL HISTORY

Occupation: _____

Do you smoke? ☐Yes ☐No How many packs/day?_____ Years?_____

Drink alcohol? ☐Yes ☐No How much?_____

Use any other drugs (marijuana, cocaine, etc.)? ☐Yes ☐No If yes, what?_____

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed

Live Alone? ☐Yes ☐No If no, who do you live with? _____

REPRODUCTIVE HISTORY

Women:

Age when menstrual cycle began: _____ Date of last period: _____

Difficulty with periods? ☐Yes ☐No

Total pregnancies_____ How many live births? _____

Miscarriages or abortions? ☐Yes ☐No How many? _____

Any medical problems associated with pregnancy or any other gynecological illnesses? ☐Yes ☐No

History of breast disease? ☐Yes ☐No Do you perform regular breast exams? ☐Yes ☐No

Date of last PAP smear_____ Date of last mammogram_____

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REPRODUCTIVE HISTORY

Men:

Do you perform regular testicular self-exams? ☐Yes ☐No

Any problems with testicular, prostate, or infertility? ☐Yes ☐No If yes, please explain:_____

ALLERGIES _____

PHARMACY Name:_____Location:_____

CURRENT MEDICATIONS **include dosage and frequency for each

Medication	Dosage	Frequency

REVIEW OF SYSTEMS

In the past few months, have you had any of the following symptoms or difficulties? If you have any difficulty that needs further explanation please indicate such and explain in additional notes section.

General	YES	NO
Loss of appetite	☐	☐
Fever or chills	☐	☐
Eyes	☐	☐
Blurred vision	☐	☐
Loss of vision	☐	☐
Head/ear/nose/throat	☐	☐
Hoarseness	☐	☐
Trouble swallowing	☐	☐
Cardiovascular	☐	☐
Chest pain	☐	☐
Leg swelling	☐	☐
Varicose veins	☐	☐

Respiratory	YES	NO
Shortness of breath	☐	☐
Wheezing	☐	☐

Gastrointestinal	YES	NO
Nausea and vomiting	☐	☐
Ulcers	☐	☐
Blood in stool	☐	☐
Change in bowel habits	☐	☐
Kidney/bladder/urine	☐	☐
Painful urination	☐	☐
Frequent urination	☐	☐

Musculoskeletal	YES	NO
Significant pain/stiffness	☐	☐
Skin	☐	☐
Rash	☐	☐
Frequent rashes	☐	☐

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Neurological	**YES**	**NO**
Tremor	☐	☐
Seizures	☐	☐
Stroke	☐	☐

Psychiatric	**YES**	**NO**
Mental Illness	☐	☐
Suicide Attempt	☐	☐
Depression	☐	☐
Drug/Alcohol addiction	☐	☐
Difficulty with sexual activities	☐	☐

Endocrine	**YES**	**NO**
Thyroid disease	☐	☐

Hematological/Lymphatic	**YES**	**NO**
Easy bruising	☐	☐

Immunologic	**YES**	**NO**
Enlarged/swollen lymph glands	☐	☐

Mark all that apply:	**YES**	**NO**
Recent weight loss	☐	☐
Low energy/fatigue	☐	☐
Double Vision	☐	☐
Eye pain	☐	☐
Hearing loss	☐	☐
Ear pain	☐	☐
Palpitations	☐	☐
Orthopnea	☐	☐
Chronic cough	☐	☐
Heartburn	☐	☐
Constipation	☐	☐
Hemorrhoids	☐	☐
Blood in urine	☐	☐
Change in urinary pattern	☐	☐
Itching	☐	☐
Dizziness	☐	☐
Tingling	☐	☐
Suicidal Thoughts	☐	☐
Trouble sleeping (insomnia)	☐	☐
Heat/cold tolerance	☐	☐
Easy bleeding	☐	☐

Additional Notes:_____

_____

_____

_____