Medical History
(please mark those that apply)

<table>
<thead>
<tr>
<th>Condition</th>
<th>Condition</th>
<th>Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angina/Chest Pain</td>
<td>GERD (reflux)</td>
<td>Osteoarthritis</td>
</tr>
<tr>
<td>Coronary Artery Disease</td>
<td>Irritable Bowel Syndrome (IBS)</td>
<td>Rheumatoid arthritis</td>
</tr>
<tr>
<td>Valvular Heart Disease</td>
<td>Crohn’s Disease (IBD)</td>
<td>Gout</td>
</tr>
<tr>
<td>Arrhythmias (Afib, WPW, etc.)</td>
<td>Ulcerative Colitis (IBD)</td>
<td>Osteoporosis</td>
</tr>
<tr>
<td>Hypertension</td>
<td>Pancreatitis</td>
<td>Fibromyalgia</td>
</tr>
<tr>
<td>Hyperlipidemia</td>
<td>Peptic Ulcer Disease</td>
<td>Chronic low back pain</td>
</tr>
<tr>
<td>Congestive Heart Failure</td>
<td>Gastritis</td>
<td>Chronic Joint Pain (please specify):</td>
</tr>
<tr>
<td>Abdominal Aneurysm</td>
<td>Hemorrhoids</td>
<td></td>
</tr>
<tr>
<td>History of MI</td>
<td>Chronic Constipation</td>
<td></td>
</tr>
<tr>
<td>Peripheral Vascular Disease</td>
<td>Fecal Incontinence</td>
<td></td>
</tr>
<tr>
<td>Syncope</td>
<td>Hepatitis</td>
<td>Hearing loss</td>
</tr>
<tr>
<td>Diabetes Mellitus</td>
<td>Fatty Liver</td>
<td>Glaucoma</td>
</tr>
<tr>
<td>Hypothyroidism</td>
<td>Abnormal Colonoscopy (please specify):</td>
<td>Cataracts</td>
</tr>
<tr>
<td>Hyperthyroidism</td>
<td></td>
<td>Vision loss</td>
</tr>
<tr>
<td>Anemia</td>
<td>Headaches</td>
<td></td>
</tr>
<tr>
<td>Bleeding Disorder</td>
<td>Stroke (CVA) or TIA</td>
<td>Psoriasis</td>
</tr>
<tr>
<td>Clotting Disorder</td>
<td>Seizures/Epilepsy</td>
<td></td>
</tr>
<tr>
<td>Thrombocytopenia</td>
<td>Peripheral Neuropathy</td>
<td></td>
</tr>
<tr>
<td>Deep Vein Thrombosis (DVT)</td>
<td>Restless Leg Syndrome</td>
<td>Chickenpox</td>
</tr>
<tr>
<td>Pulmonary Embolism (PE)</td>
<td>Dementia</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Parkinson’s Disease</td>
<td>MRSA</td>
</tr>
<tr>
<td>COPD</td>
<td>Multiple Sclerosis</td>
<td>Tuberculosis/Abnormal PPD (please specify):</td>
</tr>
<tr>
<td>Asthma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sleep Apnea</td>
<td>Depression</td>
<td>Rubella</td>
</tr>
<tr>
<td>Chronic Kidney Disease</td>
<td>Anxiety</td>
<td>Polio</td>
</tr>
<tr>
<td>Urinary incontinence</td>
<td>Bipolar Disorder</td>
<td>Mumps</td>
</tr>
<tr>
<td>Kidney Stones</td>
<td>Anorexia</td>
<td>Measles</td>
</tr>
<tr>
<td>Recurrent UTI</td>
<td>Bulimia</td>
<td>Rheumatic fever</td>
</tr>
<tr>
<td>Interstitial Cystitis</td>
<td>ADD/ADHD</td>
<td></td>
</tr>
<tr>
<td>Hematuria</td>
<td>Autism Spectrum Disorder</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Learning delay</td>
<td></td>
</tr>
<tr>
<td>Cancer (specify type):</td>
<td>Other (please specify):</td>
<td></td>
</tr>
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</table>

Please be sure to continue to next page...
Surgical History

<table>
<thead>
<tr>
<th>Date</th>
<th>Date</th>
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</thead>
<tbody>
<tr>
<td>Tonsillectomy</td>
<td>Cholecystectomy</td>
<td>Mastectomy</td>
</tr>
<tr>
<td>Dental Surgery</td>
<td>Appendectomy</td>
<td>Lumpectomy</td>
</tr>
<tr>
<td>Heart Cath</td>
<td>Splenectomy</td>
<td>Breast biopsy</td>
</tr>
<tr>
<td>Coronary Stent</td>
<td>Colonscopy</td>
<td></td>
</tr>
<tr>
<td>CABG</td>
<td>Bowel resection</td>
<td>Skin cancer removal</td>
</tr>
<tr>
<td>Pacemaker/Defibrillator</td>
<td>Hernia repair</td>
<td></td>
</tr>
<tr>
<td>Valve Replacement</td>
<td>Gastric bypass</td>
<td>Cesarean Section</td>
</tr>
<tr>
<td>Thyroidectomy</td>
<td>Bladder Surgery</td>
<td>Bilateral Tubal Ligation</td>
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<tr>
<td>Parathyroidectomy</td>
<td>Kidney Surgery</td>
<td>Hysterectomy</td>
</tr>
<tr>
<td>Spine Surgery (please specify):</td>
<td>Joint replacement (please specify):</td>
<td>Ovary removal</td>
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<tr>
<td></td>
<td></td>
<td>LEEP</td>
</tr>
<tr>
<td></td>
<td></td>
<td>D&amp;C</td>
</tr>
<tr>
<td>Other (please specify):</td>
<td></td>
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</table>

Family History
(please mark those that apply)

<table>
<thead>
<tr>
<th>Father</th>
<th>Mother</th>
<th>Sibling</th>
<th>Children</th>
<th>Maternal Grandma</th>
<th>Maternal Grandpa</th>
<th>Paternal Grandma</th>
<th>Paternal Grandpa</th>
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<tbody>
<tr>
<td>Diabetes Mellitus</td>
<td>Thyroid disease</td>
<td>Hypertension</td>
<td>Hyperlipidemia</td>
<td>Coronary Artery Disease</td>
<td>Congestive Heart Failure</td>
<td>Heart attack (MI)</td>
<td>Arrhythmia</td>
</tr>
<tr>
<td>Stroke</td>
<td>Dementia</td>
<td>Asthma/COPD</td>
<td>Bleeding disorder</td>
<td>Clotting disorder</td>
<td>Autoimmune disorder</td>
<td>Depression</td>
<td>Addiction</td>
</tr>
<tr>
<td>Kidney Disease</td>
<td>Cancer (please specify):</td>
<td>Other (please specify):</td>
<td></td>
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</tbody>
</table>

Please be sure to continue to next page...
OB/GYN History (females only)

Age Periods Started: _______  Age Periods Stopped: _______

Last Menstrual Period: _______  Average length of period: _______  Average length between periods: _______

# of Pregnancies: _______  # of miscarriages: _______  # of live births: _______

Birth Control Method: ______________________

Last Pap Smear (date/results): ______________________

Last Mammogram (date/results): ______________________

Current Medications: (please include any over the counter medications & herbal supplements)

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Strength</th>
<th>Frequency</th>
<th>Medication Name</th>
<th>Strength</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
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</tr>
</tbody>
</table>

Preferred Pharmacy: ______________________

Allergies (medications, food, environmental, etc.)

____________________________________________

____________________________________________

____________________________________________

Social History

Tobacco Use: Current: YES  NO  If yes, how many packs per day? _________  How long? _________

Past: YES  NO  when did you quit? _________

Secondhand exposure: YES  NO

Alcohol Use: YES  NO  If yes, how much/often? ________________________________

Substance Use: □ None  □ Marijuana  □ Opiates  □ Cocaine  □ Heroin  □ Amphetamines  □ Hallucinogens
□ Other (please specify): ________________________________

Preferred Language:
□ English  □ Spanish  □ Other: _____________

The information given in this medical history is accurate to the best of my knowledge.

Signature: ________________________________  Date: _____
DALHART FAMILY MEDICINE CLINIC
206 E 16TH ST DALHART, TEXAS 79022
Phone: (806) 244-5668 Fax: (806) 244-5912

ADULT MEDICAL INFORMATION

Name: ___________________________ DOB: ___________ Date: ___________________________

Please answer all questions completely and to the best of your knowledge.

PAST MEDICAL HISTORY: (Check conditions you have or have had in the past.)

- Anemia
- Asthma
- Bronchitis
- Diabetes
- Hepatitis
- HIV positive
- Mononucleosis
- Prostate problems
- Suicide attempt
- Anorexia
- Bleeding disorders
- Bulimia
- Epilepsy
- Hernia
- Psychiatric care
- Thyroid problems
- Breast lump
- Blood transfusion
- Cancer
- Heart Attack
- Heart disease
- Chicken pox
- Measles
- Mumps
- Pneumonia
- Polio

Please list any other ongoing medical problems and their approximate start date.

____________________________________________________________________________________

____________________________________________________________________________________

OB/GYN History (female only):

Age of first period________yrs. Old Number of pregnancies_______ Number of children________

Last mammogram_______ Ever abnormal? No/Yes If yes, what treatment?____________________

Last pap______________ Ever abnormal? No/Yes If yes, what treatment?____________________

Last menstrual period started____________ OR Date of menopause________________________

Cycle length____________________days Date of surgical hysterectomy_____________________

Heaviness of menstrual flow Hvy / Med / Light Reason for hysterectomy____________________

Type of birth control used__________________________

MEDICATIONS: (please list all your current medications and doses, include over the counter meds & supplements taken regularly)

____________________________________________________________________________________

____________________________________________________________________________________

PREFERRED PHARMACY: ________________________________________________________________

MEDICATIONS ALLERGIES: _____________________________________________________________

OTHER ALLERGIES: _________________________________________________________________

IMMUNIZATION HISTORY: (Please list date of last immunization and provide a copy of your childhood immunization record)

Tetanus booster ___________________________

Influenza (flu shot) _______________________

Pneumovac (pneumonia shot)______________

Hepatitis B series _________________________

BE SURE TO COMPLETE BACK AND SIGN
FAMILY HISTORY: (please circle any diseases that run in your family and list relatives affected)

- Arthritis
- Autoimmune disease
- Bleeding disorder
- Cancer
- Congenital defects
- Diabetes
- Epilepsy
- GI disorder
- Other:

- Gout
- Heart disease
- High blood pressure
- Kidney disease
- Lung disease
- Mental Illness
- Stroke
- Tuberculosis

SOCIAL HISTORY: (please fill in blanks and circle the most accurate answers as appropriate)

- How often do you use tobacco? Never / Rarely / Occasionally / Daily ______ per day Type: Cig/ Cigar/ Pipe/ Snuff/ Chew
- How often do you drink caffeinated drinks? Never/ Rarely/ Occasionally/ Daily ______ per day
- How often do you exercise? Never/ Rarely/ Occasionally/ Daily ______ per day
- How often do you drink alcohol? Never/ Rarely/ Occasionally/ Daily ______ per day
- How often do you use illegal drugs? Never/ Rarely/ Occasionally/ Daily ______ per day

REVIEW OF SYMPTOMS: (please circle any symptoms you currently have or have had in the recent past)

- GENERAL:

- MUSCLE/Joint/Bone:

- GENITOURINARY:
  - Bleeding between periods. Excessive bleeding with periods.

- CARDIOVASCULAR:

- RESPIRATORY:

- HEENT:

- SKIN:

- NEUROLOGIC:

- PSYCHOLOGICAL:

The information given in this medical history is accurate to the best of my knowledge.

Signature: ___________________________ Date: ___________________________
DALHART FAMILY MEDICINE CLINIC
206 E 16TH ST DALHART, TEXAS 79022
Phone: (806) 244-5668 Fax: (806) 244-5912

CHILD MEDICAL HISTORY
(To be completed by parent or guardian)

Child’s Name: ___________________________ DOB: __________ Date: __________

Please answer all questions completely and to the best of your knowledge.

BIRTH HISTORY:
Child delivered at Term (9mths) Premature by ___ wks. Late by ___ wks.
Child delivered by Normal vaginal delivery OR C-Section Birth weight ___ lbs ___ oz. Length ___
Complications at birth or during pregnancy?

PAST MEDICAL HISTORY: (Check conditions child has or has had in the past.)

Acne  ADHD  Allergies  Anemia
Asthma  Behavior problems  Bleeding disorders  Bronchitis
Bulimia  Cancer  Cataracts  Chemical dependency
Chicken pox  Developmental delay  Diabetes  Eczema (atopic dermatitis)
Epilepsy  Heart disease  Heart failure  Hepatitis
Hernia  High blood pressure  High cholesterol  HIV positive
Kidney disease  Learning disability  Liver disease  Measles
Pneumonia  Polio  Premature birth  Psoriasis
Psychiatric care  Rheumatic fever  Tubes in ears  Urinary tract infection

Please list any other ongoing medical problems and there approximate start date.

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

Please list any other Physicians or Healthcare providers your child sees, and the reason seen:

____________________________________________________________________________________

MEDICATIONS: (Please list all current medications and doses, include over the counter meds & supplements taken regularly)

____________________________________________________________________________________

MEDICATION ALLERGIES: (please list)

____________________________________________________________________________________

OTHER ALLERGIES: (please list)

____________________________________________________________________________________

IMMUNIZATION HISTORY (please list date of last immunization and provide a copy of immunization record)
Tetanus booster _____________ Flu shot _____________ Pneumonia vaccine _____________
Hepatitis B series _____________ Chicken pox vaccine _____________ or approx date of Chicken pox

I AUTHORIZE THE FOLLOWING PERSON(S) TO BRING MY CHILD, AS NAMED ABOVE, TO HCCRHC FOR TREATMENT ON MY BEHALF.

Name of authorized person Relationship to child Name of authorized person Relationship to child

____________________________________________________________________________________

Signature of parent or guardian Date

BE SURE TO COMPLETE BACK AND SIGN
GYN HISTORY: (only if already had first menses)
Age of first period ___________ yrs old
Last menstrual period started ______________
Cycle length ________ days (regular / irregular)
Heaviness of menstrual flow  Hvy / Med / Light

FAMILY HISTORY: (please circle any diseases that run in your family and list relatives affected)
Arthritis ________________________________ Asthma _____________________________
Autoimmune ______________________________ Bleeding disorder _____________________
Birth defects ______________________________ Cancer _____________________________
Diabetes _________________________________ Epilepsy ____________________________
GI disorder ______________________________ Heart disease _______________________
Kidney disease __________________________ Lung disease _________________________
Mental illness ____________________________ Tuberculosis _________________________
Other ____________________________________________________

REVIEW OF SYMPTOMS: (please skip this section if child is less than two years old.)
Please circle any symptoms your child currently has:


Palpitations.


The information given in this medical history is accurate to the best of my knowledge.

_________________________________________  ________________________________  __________
Signature                                   Relationship to child              Date
Patient acknowledgement that you read and can receive a copy of our HIPPA Privacy Practices dated September 23, 2013.

Patient Name: ___________________________  Date of Birth: ___________________________

☑️ I do NOT authorize any information to be discussed with any family members or friends.
☑️ I authorize information about treatment or appointments to be discussed with the following

Person(s): ________________________________________________________________

I have read and understand the above information.

__________________________________________________________________________  ____________________________
Patient/Guardian Signature  Date
DRAFT CHOICE OF LAW AND FORUM CLAUSE

NONEMERGENCY AGREEMENT AS TO GOVERNING LAW AND FORUM

The patient, including patient’s representative and heirs or beneficiaries, and the health care provider, including employees and agents of the health care provider, rendering or providing medical care, health care, or safety or professional or administrative services directly related to health care to patient agree:

1. That all health care rendered shall be governed exclusively and only by Texas law, and in no event shall the law of any other state apply to any health care rendered to patient; and
2. In the event of a dispute, any lawsuit, action, or cause of which in any way relates to health care provided to the patient shall be brought only in a Texas court in the county/district where all or substantially all of the health care was provided or rendered, and in no event will any lawsuit, action, or cause of action ever be brought in any other state. The choice of law and forum selection provisions of this paragraph are mandatory and are not permissive.

Signature of Patient ___________________________ Date ____________

NON ES DE EMERGENCIA ACUERDO CON RESPETO A LA LEY APLICABLE Y FORO:

El paciente, incluyendo el representante del paciente, y herederos o beneficiarios, y el proveedor de cuidado de la salud, incluyendo a los empleados y agentes del proveedor de atención médica, la prestación o la prestación de asistencia médica, cuidados de la salud, o servicios de seguridad o profesionales o administrativos directamente relacionados con la atención sanitaria a los pacientes de acuerdo de:

1. Que todo cuidado de la salud se regirán exclusivamente y sólo por la Ley de Texas y en ningún caso la ley de cualquier otro estado aplicará a cualquier cuidado de la salud prestada al paciente; y
2. En el caso de una disputa, cualquier demanda, acción o causa que de alguna manera se relaciona con el cuidado de la salud proporcionado al paciente sólo será llevada en un tribunal de Texas en el condado / distrito donde todo o sustancialmente todo cuidado de la salud fue prestada o proporcionada y en ningún caso cualquier demanda, acción o causa de acción nunca será llevada en cualquier otro estado. La elección de las disposiciones legales y selección de foro de este párrafo son obligatorios y no son permissivas.

Signature of Patient ___________________________ Date ____________
NOTICE OF FINANCIAL RESPONSIBILITY

I________________________________________ (parent /guardian/ responsible party’s name) have been notified by clinic staff (physician/provider) that my insurance____________________________________ may deny payment of certain health care services. If my insurance denies payment I understand that I will be personally and fully responsible for payment of services rendered. I also understand that I can personally appeal or discuss such denial of coverage with my insurance company and that covered services may change at any time without notification due to me.

________________________________________
Patient signature (Guardian if minor) Date

________________________________________
Witness/Clinic Staff signature Date