DHCHD
Dallam Hartley Counties
Hospital District

1411 Denver Avenue
Dalhart, Texas 79022
www.dhchd.or

DALHART FAMILY MEDICINE CLINIC

206 E 16TH ST DALHART, TEXAS 79022

Phone: (806) 244-5668 Fax: (806) 244-5912

Medical History

(please mark those that apply)

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

Please be sure to continue to next page…

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Surgical History

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

Family History

(please mark those that apply)

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

Please be sure to continue to next page…

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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)

Medication Name	Strength	Frequency	Medication Name	Strength	Frequency

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:** _

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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	____Anorexia	____Appendicitis	____Arthritis
____Asthma	____Bleeding disorders	____Blood transfusion	____Breast lump
____Bronchitis	____Bulimia	____Cancer	____Chicken pox
____Diabetes	____Epilepsy	____Heart Attack	____Heart disease
____Hepatitis	____Hernia	____Herpes	____High blood pressure
____HIV positive	____Kidney disease	____Measles	____Migraine headaches
____Mononucleosis	____Mumps	____Pneumonia	____Polio
____Prostate problems	____Psychiatric care	____Rheumatic fever	____Scarlet fever
____Suicide attempt	____Thyroid problems	____Tuberculosis	

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

_____
_____
_____
_____

Please list all **operations** and **significant illnesses** Along with approximate dates.

_____
_____
_____
_____

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 _____

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FAMILY HISTORY: (please circle any diseases that run in your family and list relatives affected)

Arthritis	_____	Gout	_____
Autoimmune disease	_____	Heart disease	_____
Bleeding disorder	_____	High blood pressure	_____
Cancer	_____	Kidney disease	_____
Congenital defects	_____	Lung disease	_____
Diabetes	_____	Mental Illness	_____
Epilepsy	_____	Stroke	_____
GI disorder	_____	Tuberculosis	_____

Other: _____

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: Chills. Depression. Dizziness. Fainting. Fever. Forgetfulness. Headache. Loss of sleep. Loss of weight. Weight gain. Nervousness. Numbness. Sweats.

MUSCLE/JOINT/BONE: Pain. Weakness or numbness in: Arms. Back. Neck. Hips. Legs. Feet. Shoulders. Hands

GENITOURINARY: Blood in urine. Frequent urination. Lack of bladder control. Painful urination. Erection difficulties
Lump in testicles. Penile discharge. Sore on penis. Vaginal discharge. Painful intercourse. Bleeding between periods. Excessive bleeding with periods.

CARDIOVASCULAR: Chest pain. High blood pressure. Irregular heart beat. Low blood pressure. Poor circulation. Rapid heart beat. Swelling of ankles. Varicose veins. Shortness of breath. Shortness of breath with exertion. Murmur. Palpitations. Sleeping on multiple pillows.

RESPIRATORY: Cough. Shortness of breath. Wheezing. Sputum production. Coughing of blood.

HEENT: Bleeding gums. Blurred vision. Crossed eyes. Difficulty swallowing. Double vision. Earache. Ear discharge. Seeing spots. Runny nose. Sneezing. Itching, watery eyes. Burning eyes. Hoarseness. Loss of hearing. Nose bleeds. Ringing in ears. Sinus problems.

SKIN: Bruise easily. Hives. Itching. Change in moles. Rash. Sore that won't heal. Swelling. Color change.

NEUROLOGIC: Memory loss. Tremors. Fainting. Dizziness. Seizures. Headaches. Confusion. Difficulty speaking.

PSYCHOLOGICAL: Depression. Anxiety. Thoughts of suicide. Hallucinations. Paranoia. Mood swings.

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

Signature:_____ **Date:**_____

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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 all **operations, hospitalizations, and Significant illness** along with approximate dates.

_____

_____

_____

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

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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:

GENERAL: Chills. Depression. Dizziness. Fainting. Fever. Forgetfulness. Headache. Loss of sleep. Loss of weight. Weight gain. Nervousness. Numbness. Sweats.

MUSCLE/JOINT/BONE: Blood in urine. Frequent urination. Painful urination. Lack of bladder control. Bed wedding.

GASTROINTESTINAL: Poor appetite. Bloating. Bowel changes. Constipation. Diarrhea. Excessive hunger. Excessive thirst. Gas. Nausea. Rectal bleeding. Stomach pain. Soiling of underpants. Vomiting. Vomiting blood.

CARDIOVASCULAR: Chest pain. Irregular heart beat. Rapid heartbeat. Shortness of breath with exertion. Murmur. Palpitations.

RESPIRATORY: Cough. Shortness of breath. Wheezing. Sputum production. Coughing of blood.

HEENT: Bleeding gums. Crossed eyes. Difficulty swallowing. Double vision. Earache. Ear discharge. Runny nose. Sneezing. Itching. Watery eyes. Burning eyes. Hoarseness. Loss of hearing. Nose bleeds. Ringing in ears. Sinus problems. Blurred vision. Glasses or Contacts.

SKIN: Bruise easily. Hives. Itching. Rash. Sore that won't heal. Swelling.

NEUROLOGIC: Fainting. Dizziness. Seizures. Headaches. Confusion. Concussion.

PSYCHOLOGICAL: Depression. Anxiety. Thoughts of suicide. Hallucinations. Paranoia. Mood swings.

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

_____ _____ _____

Signature **Relationship to child** **Date**

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Patient acknowledgement that you read and can receive a copy of our HIPPA Privacy Practices dated September 23, 2013.

Patient Name:_____ Date of Birth: _____

- ϒ I do NOT authorize any information to be discussed with any family members or friends.
- ϒ 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

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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

NO 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 permisivas.

Signature of Patient Date

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NOTICE OF FINANACIAL RESPONSIBILITY

Patient's name:_____ Date of Birth:_____

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