# Medical History

(please mark those that apply)

<table>
<thead>
<tr>
<th>Condition</th>
<th>Condition</th>
<th>Condition</th>
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</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>
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<tr>
<td>History of MI</td>
<td>Chronic Constipation</td>
<td></td>
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<tr>
<td>Peripheral Vascular Disease</td>
<td>Fecal Incontinence</td>
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<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>
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<td>Vision loss</td>
</tr>
<tr>
<td>Anemia</td>
<td>Headaches</td>
<td>Acne</td>
</tr>
<tr>
<td>Bleeding Disorder</td>
<td>Stroke (CVA) or TIA</td>
<td>Eczema</td>
</tr>
<tr>
<td>Clotting Disorder</td>
<td>Seizures/Epilepsy</td>
<td>Psoriasis</td>
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<tr>
<td>Thrombocytopenia</td>
<td>Peripheral Neuropathy</td>
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<tr>
<td>Deep Vein Thrombosis (DVT)</td>
<td>Restless Leg Syndrome</td>
<td>Chickenpox</td>
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<td>Pulmonary Embolism (PE)</td>
<td>Dementia</td>
<td>HIV/AIDS</td>
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<tr>
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<td>Parkinson’s Disease</td>
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<tr>
<td>COPD</td>
<td>Multiple Sclerosis</td>
<td>Tuberculosis/Abnormal PPD (please specify):</td>
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<tr>
<td>Asthma</td>
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<td>Sleep Apnea</td>
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<td>Rubella</td>
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<td>Recurrent UTI</td>
<td>Bulimia</td>
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<td>Interstitial Cystitis</td>
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<td>Cancer (specify type):</td>
<td>Learning delay</td>
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<td>Other (please specify):</td>
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Please be sure to continue to next page...
### Surgical History

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<th>Procedure</th>
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<td>Appendectomy</td>
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<td>Lumpectomy</td>
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<td>Heart Cath</td>
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<td>Splenectomy</td>
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<td>Breast biopsy</td>
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<td>Coronary Stent</td>
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<td>Colonoscopy</td>
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<td>CABG</td>
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<td>Bowel resection</td>
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<td>Skin cancer removal</td>
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<td>Hernia repair</td>
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<td>Valve Replacement</td>
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<td>Gastric bypass</td>
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<td>Bladder Surgery</td>
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<td>Bilateral Tubal Ligation</td>
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<td>Parathyroidectomy</td>
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<td>Other (please specify):</td>
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### Family History

(please mark those that apply)

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<tr>
<th>Health Condition</th>
<th>Father</th>
<th>Mother</th>
<th>Sibling</th>
<th>Children</th>
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<tbody>
<tr>
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<td>Thyroid disease</td>
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<td>Hypertension</td>
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<td>Congestive Heart Failure</td>
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<td>Heart attack (MI)</td>
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<td>Asthma/COPD</td>
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<td>Kidney Disease</td>
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<td>Cancer (please specify):</td>
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<td>Other (please specify):</td>
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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>
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</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: ____________________________
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 and their 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 ____________________________

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)


- Lump in testicles
- Penile discharge
- Sore on penis
- Vaginal discharge
- Painful intercourse
- Bleeding between periods
- Excessive bleeding with periods


- Rapid heart beat
- Swelling of ankles
- Varicose veins
- Shortness of breath
- Shortness of breath with exertion
- Murmur
- Palpitations
- Sleeping on multiple pillows


- Ear discharge
- Seeing spots
- Runny nose
- Sneezing
- Itching, watery eyes
- Burning eyes
- Hoarseness
- Loss of hearing
- Nose bleeds
- Ringing in ears
- Sinus problems


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

Signature: _______________________________ Date: _______________________________
HIGH COUNTRY RURAL HEALTH CLINIC
320 E. Texas Blvd. DALHART, TEXAS 79022
Phone: (806) 244-8324    Fax: (806) 249-8412

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.)
\[Check boxes and list conditions here.\]

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 ____________________________
Gl 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
HIGH COUNTRY RURAL HEALTH CLINIC
320 E. Texas Blvd. DALHART, TEXAS 79022
Phone: (806) 244-8324       Fax: (806) 249-8412

Patient acknowledgement that you read and can receive a copy of our

Patient Name:  ____________________________  Date of Birth:  ____________________________

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

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 permissivas.

__________________________
Signature of Patient  
__________________________
Date
NOTICE OF FINANCIAL 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