

**NEW PATIENT INFORMATION RECORD
IMPACT PHYSICIANS OF TEXAS, P.A.**

NAME: _____ **DATE:** _____

REASON FOR YOUR VISIT TODAY? _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: (____) _____ WORK: (____) _____ CELL: (____) _____

DRIVER'S LICENSE #: _____ STATE: _____ DATE OF BIRTH: ____ / ____ / ____ GENDER: M OR F

SS#: _____ MARTITAL STATUS: S / M / W / D / SEP SPOUSE'S NAME: _____

EMPLOYER: _____ OCCUPATION: _____

WHO REFERRED YOU TO IMPACT Physicians of Texas PHYSICIAN: _____

(PLEASE CIRCLE ONE) YELLOW PAGES, PHONE BOOK, FRIEND, EMPLOYER, OTHER

PAST MEDICAL HISTORY (list any diseases and describe):

1. _____
2. _____
3. _____
4. _____
5. _____

PAST SURGICAL HISTORY:

Operations (Include Biopsies)	Year	Surgeon	Reason for Surgery
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

CURRENT MEDICATIONS (list dosage and frequency, if known):

CURRENT SPECIALISTS:

Name	Address	Phone
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_____	_____	_____
_____	_____	_____
_____	_____	_____

DRUG ALLERGIES:

FAMILY HISTORY:

Has anyone in your family had:

- | | | |
|--|--|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer | <input type="checkbox"/> High/abnormal Cholesterol |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Other _____ |

PERSONAL HABITS:

Do you: smoke Y N drink alcohol Y N

PATIENT NAME:

DATE:

PERIODIC EXAMINATIONS:

When was your last.....

Pap Smear _____

Rectal Exam _____

Test for blood in stool _____

Colonoscopy _____

Mammogram _____

Chest X-Ray _____

EKG _____

Blood work _____

EMERGENCY CONTACT (NAME & PHONE NUMBER)

LIST OF INDIVIDUALS WITH WHOM WE MAY DISCUSS YOUR TREATMENT OR RELEASE RECORDS TO:
