

Date: _____

PATIENT REGISTRATION

Name _____ Date of Birth _____ Age _____
Last First Initial

Address _____ Home phone (_____) _____
Street

_____ Work phone (_____) _____
City State Zip Code

Employer _____ How Long? _____ Cell phone (_____) _____

Social Security Number _____ Driver's License Number _____ State _____

Spouse _____ Spouse's Employer _____

In Case of Emergency Contact:

Name _____ Relationship _____ Home Phone (_____) _____

Address _____ Work phone (_____) _____
Street City/State Zip Code

Nearst Relative Not Living With You:

Name _____ Relationship _____ Home Phone (_____) _____

Address _____ Work phone (_____) _____
Street City/State Zip Code

Signature _____ Date _____

NOTICE CONCERNING COMPLAINTS
Complaints about physicians, as well as other licensees and registrants of the Texas State Board of Medical Examiners, including physician assistants and acupuncturists, may be reported for investigation at the following address:
Texas State Board of Medical Examiners
Attn: Investigations
1812 Centre Creek Drive, Suite 300
P.O. box 149134
Austin, Texas 78714-9134
Assistance in filing a complaint is available by calling the following telephone number:
1-800-201-9353.

AVISO SOBRE QUEJAS
Se pueden presentar quejas acerca de medicos, asi tambien como de otras personas autorizadas y registradas por la Junta de Examinadores Medicos del Estado de Texas (Texas State Board of Medical Examiners), incluyendo a ayudantes medicos y acupunturistas, para su investigacion, en las siguiente direccion:
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Attn: Investigations
1812 Centre Creek Drive, Suite 300
P.O. box 149134
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1-800-201-9353.

PATIENT'S HISTORY

Marital Status _____

What type of work do you do? _____

Significant hobbies/sports _____

If you are a student, what is your field of study? _____

Past Obstetric History Pregnancies (including miscarriages and abortions)

Number	Year	Months at Delivery	Infant Size	Living?	Labor Length	Complications?
1						
2						
3						
4						
5						

History of Abnormal PAP Smears _____

Major on-going non-gynecological problems _____

Describe Hospitalizations and Surgeries other than those relating to information above:

____ Year Reason _____

____ Year Reason _____

____ Year Reason _____

____ Year Reason _____

____ Year Reason _____

____ Year Reason _____

____ Year Reason _____

Current Medicines _____

Drug Allergies _____

Do you smoke? Yes No How much? _____ For how long? _____

Do you drink alcohol? Yes No How much? _____ For how long? _____

Have you ever had a blood transfusion? Yes No

FAMILY HISTORY

Relation	Alive?	Age now or age at death	Current Health Status	Cause of Death
Mother				
Father				
Sibling				
Sibling				
Sibling				
Sibling				
Sibling				
Children				
Children				
Children				
Children				

Do you have a family history of any of the following: _____

<input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No Spinal Cord Disease
<input type="checkbox"/> Yes <input type="checkbox"/> No High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No Birth Defects
<input type="checkbox"/> Yes <input type="checkbox"/> No Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No Mental Retardation
<input type="checkbox"/> Yes <input type="checkbox"/> No Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No Downs Syndrome
<input type="checkbox"/> Yes <input type="checkbox"/> No Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No Other
<input type="checkbox"/> Yes <input type="checkbox"/> No Sickle Cell Disease	Birth Related Disorders _____