HEALTH HISTORY FORM

23960 Katy Fwy Ste 320
Katy, TX, 77494
Tel: 281-599-9979
Fax: 281-599-3540

Patient Name:____ **Today's Date:**________________

Age:______________**Birth Date** __________________**Male**______**Female**_____**Unknown**____________

Date of last physical Examination__________ **What is your reason for Visit?**________________________

Email (Please Print)____

Home Address:____

City:______________________**State:**_________**Zip code:**_____________

Home Phone#:__________________**Cell#:**____________________**Work #:**_____________________

Is it OK to leave message: Yes_______ **NO**_______

Emergency Contact: (name & Address)____

____

Phone#______________________**Cell#**__________________**Relationship to Pt:**________________________

Pharmacy Name:____ **Phone#:**____________________________

SYMTOMS

check() symptoms you currently have (Check that applies)

◯ WT LOSS	◯ RASH	◯ HEADACHE	◯ BLURRED VISION	◯ CATARACTS
◯ WT GAIN	◯ LUMPS	◯ DHIZINESS	◯ TINNITUS	◯ CHEST PAIN
◯ FATIQUE	◯ SORES	◯ SYNCOPE	◯ DISCHARGE	◯ HEART ATTACK
◯ FEVER	◯ ITCHING	◯ VERTIGO	◯ EAR INFECT	◯ HIGH BLOOD PRESSURE
◯ CHILLS	◯ CANCER	◯ VISUAL CHANGES	◯ GLASSES	◯ MURMUR
◯ NO APPETITE	◯ BRUISES	◯ PAIN	◯ GLAUCOMA	◯ IREGULAR HEAR BEATS

THROAT	RESPIRATORY	MUSCULO/SKELETAL	FEMALE ONLY
◯ TONSILLITIS	◯ SHORT OF BREATH	◯ PAIN	◯ PAINFUL PERIODS
◯ DIFFICULTY SWALLOWING	◯ TUBERCULOSIS	◯ ARTHRITIS	◯ ABNORMAL PAP
◯ BLEEDING GUM	◯ COPD	◯ FRACTURE	◯ CONTRACEPTION
◯ SURGERY	◯ SMOKING	◯ SURGERY	◯ BLEEDING BETWEEN PERIOD
◯ HOARSENESS	◯ ASTHMA	◯ RUPTURED	◯ BREAST LUMP
	◯ WHEEZING	◯ DISC	◯ NIPPLE DISCHARGE
			◯ PAINFUL INTERCOURSE
			◯ VAGINAL DISCHARGE

ENDOCRINE	NEURO-PSYCH	DIGESTIVE SYS	
◯ TEMPRETURE INTOLERANCE	◯ SYNCOPE	◯ NAUSEA	◯ OTHER
◯ DIABETIES	◯ SEIZURES	◯ VOMITING	◯ Date Of Last Period,____________
◯ HAIR LOSS	◯ WEAKNESS	◯ DIARRHEA	◯ Date Of Last PAP_____________
◯ COARSE HAIR	◯ SLEEP PROBLEMS	◯ CONSTIPATE	◯ Last Mammogram?_____________
◯ THIRST	◯ DEPRESSION	◯ JAUNDICE	◯ Are You Pregnant?_________
◯ APPETITE	◯ ALCOHOL USE	◯ HEMORRHOID	◯ No Of Children_______________
◯ URINATION	◯ DRUGS		

MEDICAL OFFICE OF KATY

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NOSE	MALE ONLY	URINARY SYS.
◯ NOSEBLEED	◯ ERECTION DIFFICULTY	◯ BURNING
◯ SURGERY	◯ BREAST LUMO	◯ URGENCY
◯ ALLERGIES	◯ LUMP IN TESTICLES	◯ FREQUENCY
◯ STUFFINESS	◯ PENIS DISCHARGE	◯ BLOOD
	◯ SORE OR PENIS	◯ IMPOTENCE

FAMILY DOCTOR NAME_______________________________________
LAST VISIT ____
TREATED FOR____
HOSPITALIZED____

Family Members that have/ had any illnesses Listed below (Circle Yes if it applies)

Diabetes	Yes	No	Asthma	Yes	No
Hypotension	Yes	No	Cancer	Yes	No
Heart Disease	Yes	No	Anxiety	Yes	No
Stroke	Yes	No	Depression	Yes	No
Anemia	Yes	No	Key Disease	Yes	No
Thyroid	Yes	No	Other ______________________		

SOCIAL HISTORY Check () all that apply

◯ ALCOHAL / DRUGS____________________ ◯ HIV /STD'S_________________ ◯ ADVANCED DIRECTIVE_______________
◯ SMOKING___________________________ ◯ DOMESTIC VIOLENCE___________________

Relationship to Insured

◯ Self ◯ Spouse ◯ Child ◯ Other

Marital Status

◯ Single ◯ Married ◯ Widowed ◯ Divorced ◯ Legally Separated ◯ Partner

Race

◯ African American ◯ Caucasian ◯ Hispanic ◯ Asian ◯ Pacific Islander ◯ Arabic
◯ Indian ◯ Bangladesh ◯ Pakistani ◯ Amer. Indian or Native Alaskan ◯ Other

CURRENT MEDICINES	ALLERGIES	SURGERIES/DATE
1)_______________________	1)_______________________	1)_______________________
2)_______________________	2)_______________________	2)_______________________
3)_______________________	3)_______________________	3)_______________________
4)_______________________	4)_______________________	4) _______________________
5)_______________________	_______________________	_______________________
6)_______________________	_______________________	_______________________
7)_______________________	_______________________	_______________________
8)_______________________	_______________________	_______________________

MEDICAL OFFICE OF KATY

AUTHORIZATION FOR RELEASE OF INFORMATION

Part A (To be Filled by Patient)

I hereby authorize the release of confidential health information from the medical record of:

Patient Name:___________________ Date of Birth_________________

Part B (to be Filled by Staff)

Information Released to:
Humera Naqvi, MD.
23960 Katy Freeway
Suite 320 Katy, TX 77494

From:
____
____
____

___Problem Listed ___Last Progress Note ___ X-ray Reports ___ Immunizations

___History/Physical ___Recent Lab Reports ___Medication List ___EKG Reports

___Other Diagnostics Reports (Specify)____

Including information's (If Applicable) pertaining to:

___Mental Health ___Alcohol ___HIV/AIDS* ___Communicable Treatment

I consent to the release of any positive or negative test results for AIDS or HIV infection, antibodies to AIDS or infection with any other causative agents of AIDS with the rest of my medical records. Also, I grunt permission to Grand Parkway Family Practice Clinic to view my RX history from external sources.

I understand theinformationreleased is for thespecific purposestatedabove. Any otheruse of this information without thewrittenconsent of the patient is prohibited. I furtherunderstand that I mayrevokethisconsent (in writing) at any time except to the extent thatthe actionhasbeen takenin reliance onit.

I understand thatI canaccess mymedical records onthe Patient Portal. Thisrecordmaycontainreports, test results, andnotes that only physician caninterpret. I understand andhavebeen advised thatI shouldo aid contact my physician regarding the entries my rued to prevent my understanding of the information contained in these entries.

I will not hold medical officeof katy for any misinterpretations of theinformationin my medical reed as a result of notconsultingmy physician forthecorrectinterpretation. If Ineed a copyof the records, I understand that you will provide thisinformation within 15 days from receipt of request andthat a minimum feefor preparing weldfurnishing thisinformationmaybecharged according to rulingsset by theTexas StateBoard of Medical Examiners.

Patient Signature / Legal Guardian:______________________________Date:________________

Guardian Relationship to patient:____________________________________

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CONSENT FORM FOR SIGNATURES ONLY

CONSENT FOR TREATMENT

I, _________________________(Please PRINT Name)
(circle one> Patient or guardian)

of _________________________authorize and direct Dr. Naqvi, to perform
(Patient's name >Please Print)

necessary diagnostic test and evaluations, as deemed medically indicated, on myself. I understand that any testing to be done and/or treatment to be given will be explained to me prior to the performance of the exam, and that I may ask questions about such testing.

____ ________________
(Signature of Patient or Legal Representative) Date

Laboratory Testing

Laboratory testing which my physician may order may not be covered by my Insurance plan. I accept financial responsibility for any laboratory charges which may not be covered.

____ ________________
(Signature of Patient or Legal Representative) Date

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. 1 understand that I am entitled to receive a copy of this document. Privacy practices are part of HIPAA laws (Health Insurance Portability and Accountability Act of 1996 and re posted on the wall near the front window. Please take a minute to read them. If you have any questions, please feel free to ask

____
(Signature of Patient or Legal Representative)

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