MacGregor Medical Center

Please fill out both sides of this form

Name:______________________________ Date:_____________

Date of birth:_________ Soc sec no:_______________ Email address:________________________

Home Address:_________________________ Apt:___ City:______________ State:___ Zip:________

Home #:______________ Mobile #:____________ Sex: M/F Occupation:__________________

Primary Language: English/Spanish/Other:_____________ Race:________ Are you Hispanic? Y/N

Born where?_________ Marital status: Single:__ Married:__ Divorced:__ Widow,Widower:__

Spouse/partner name/#:_______________/________ Emergency name/#: _____________/________

Physician at MacGregor?____________ Pharmacy name________ on (cross streets)____________

Specialists you see:____

1. **MEDICATION ALLERGIES** or side effects:_______________________type:_________________

2. **IMMUNIZATIONS** *Year received*: Tetanus:___ Pneumococcal (pneumonia):___ Gardasil:___
Hepatitis A: ___ Hepatitis B:___ Shingles (Zostavax):___

3. **FAMILY HISTORY** Circle *medical conditions* for family members (not for you), and *who* is affected:

Alcoholism	Diabetes	Migraines
Asthma	Gout	Osteoporosis
Breast cancer	Heart attack	Ovarian cancer
Colon cancer	High blood pressure	Stroke
Depression or suicide	High cholesterol	Thyroid problem

Medical problems in your: Father:__________________________ Mother:_______________________
Brother(s)/Sister(s):____(#__, alive__)
Children:____(# _)
Other details:____

4. **SOCIAL and PERSONAL HISTORY** Cigarettes/cigars/pipe/snuff (circle) *ever*? Y/N
How much tobacco did/do you use? _______packs per day Year started:___ Year stopped:____
Alcohol: Y/N If yes, amount: _____ per day? week? month? What do you drink:________________
Drugs: marijuana/cocaine/other:________ Y/N Use now: Y/N Sexually active? Y/N
How many partners/past year? __ Partners are: (male)(female) Height:_____
Exercise you do: _______________ No. of days/week:___ Change weight past year:___ lbs, up/down

5. PAST MEDICAL HISTORY please circle conditions you have, or add them:

Acid reflux (heartburn)	Glaucoma	Kidney stones
Asthma	High blood pressure	Osteoporosis
Arthritis (osteoarthritis)	High cholesterol	Sexually transmitted disease
Arthritis (rheumatoid)	High triglycerides	Sleep apnea
Cancer, type:________yr:__	Heart attack	Thyroid disease
Chronic lung disease	Heart failure	
Diabetes; yr diagnosed:___	Kidney disease	

Women: 1. Age at first period:___ 2. Number of pregnancies?___ 3. Number of deliveries___
4. Number of miscarriages: ___ 5. Number of abortions:___

6. **MEDICATIONS** (prescription and nonprescription)

Name	Dose	Times/day	Name	Dose	Times/day
1			4		
2			5		
3			6		

7. **Surgeries**: please list year after each surgery ___

___

___

8. **Hospitalizations** (exclude surgeries): please list, with year ___

___ ___

___ ___

9. **Preventive**: 1.Have you had colonoscopy? Y/N, year:___ Men: 2. Prostate exam? Y/N, year of last:___ 3.PSA? Y/N, year of last:___Women: 4. Mammogram? Y/N, year of last:___ 5. Pap smear? Y/N, year of last:___ 6.Gynecologist? Y/N, name: ______________

10. **REVIEW OF SYSTEMS**: in the ***past 2 weeks*** have you had (please circle):

General: **Appetite loss Fatigue Fever Night sweats Weight gain weight loss**

Skin: Dryness Hair loss Hives Rash

HEENT: Blurry vision Red eyes Vision loss Hearing loss Earache Runny nose Sore throat Ringing of ear(s) Stuffy nose Drainage into throat

Neck: Neck pain Swollen glands

Lungs: Cough Shortness of breath Snoring Sputum Wheezes Tightness

Heart: Chest pain Calf pain when walking Difficulty breathing lying down Difficulty breathing walking Swelling in legs Elevated blood pressure Fainting Irregular heart beat Palpitations

Intestinal: Abdominal pain Bloating Bloody stool Constipation Diarrhea Food intolerance Hemorrhoids Heartburn Nausea Vomiting Cramps

Urinary: Frequent urination Blood in urine Night (# times__) Loss of control Discharge Burning Male: Erection problems Difficulty starting Female: Painful intercourse Irregular periods (Last period? ____________)

Bones/joints: Back pain Joint pain Joint stiffness Joint swelling

Neurologic: Worse memory Dizziness Headaches Numbness Tingling Trouble walking

Psychiatric: Anxiety Depression Difficulty concentrating Irritability

Endocrine: Loss of sexual desire Excessive thirst Dry skin

Hematologic: Easy bruising Excessive bleeding

None:______ or Other and explanations:___

___

Signature:______________________________ Date:______

Approved by BOD 4.21.11

ACKNOWLEDGEMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

I have reviewed a copy of the Notice of Privacy Practices for MacGregor Medical Center. The Notice describes how my health information may be used or disclosed by MacGregor Medical Center. I understand that I should read it carefully. I am aware that the Notice may be changed at any time. I may obtain a revised copy of the Notice by calling MacGregor Medical Center's Privacy Contact Person at (210) 690-2273, or by requesting one at the MacGregor Medical Center's offices.

Signature of Patient	Printed Name	Date
Signature of Patient's Representative	Printed Name	Date

MacGregor
Medical Center - San Antonio

MacGregor Medical Center Financial Statement
For Patients Covered by Private Health Insurance

I, ______________________________ (*Print Responsible Person's Name*), understand the following MacGregor Medical Center financial policies:

- If I or the Patient is covered by more than one health insurance policy at the time of my visit, I will provide that information to MMC at that time.
- I am responsible to ensure that MacGregor Medical Center (MMC or one of its physicians is my or the Patient's designated Primary Care Provider (PCP) and that designation is effective at the time of service.
- MMC will make every attempt to verify medical insurance coverage. Insurance verification may take up to 48 hours.
- Fees for services NOT covered by my or the Patient's insurance are my responsibility.
- Co-payments and deductibles required by my or the Patient's insurance are due at the time of service.
- Account balances not paid within 120 days of service may be turned over to a collection agency.

____

Patient's Name (Print)

____

Signature of Responsible Person

____

Date