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** *mark what year each was received*: Tetanus:___ Pneumococcal (pneumonia):___
Gardasil:___ Hepatitis A: ___ Hepatitis B:___ Influenza (flu):___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	High cholesterol	Thyroid problem

Medical problems in your: Father:_____ Mother:_____
Brothers (number__):_____ Sisters (number__):_____
Daughters (number__): _____ Sons (number__): _____
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:___

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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:___ Women: 3. Mammogram? Y/N, year of last:___ 4. Pap smear? Y/N, year of last:___ 5.Gynecologist? Y/N, name: _____ 6. Do you have Advance Directives (such as a Living Will and Durable Power of Attorney for Health Care)? Y/N

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

General: **Appetite loss Fatigue Fever Night sweats Weight gain Weight loss**
Pain (if you have pain, what is the level on this scale: [0 1 2 3 4 5 6 7 8 9 10] ; where is it?_____)
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 cramps 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 (how many 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 Excess thirst Hematologic: Easy bruising Excess bleeding
None:_____ or Other and explanations:_____

Signature:_____ Date:_____

Approved by BOD: 10.21.15

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. A charge of $50 for missing an appointment is my responsibility. I understand that I may be charged a reasonable fee, determined by my physician, to fill out any forms. (FMLA, Short Term Disability, Physician Statements, etc.)
- 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.

Please note: some of the MacGregor Medical Center physicians have partial ownership in the following medical providers. There are available alternatives for referral, and on-going care is not conditioned on accepting the recommended referral.

Alamo City MRI
Forest Park Medical Centers
Huebner Sleep Center
Medi-Weightloss Clinic of San Antonio

_____
Patient's Name (Print)

_____
Signature of Responsible Person

_____
Date