Mason Park Medical Clinic
21770 Kingsland Blvd
Katy, Texas 77450

Phone Number: 281-646-0740
Fax Number: 281-646-0743
Family Practice

Patient Information

First Name: _____ Last Name: _____

Sex: Male / Female **Date of Birth: _____** (MM/DD/YYYY)

Social Security: _____ (### - ## - #####)

Contact Information

Cell Phone: _____ Work Phone: _____

Email: _____ (Online Medical Records)

Street Address: _____

City: _____ State: _____ Zip Code: _____

Insurance Information

Insurance Company: _____ Effective Date: _____

Insurance ID: _____ Insurance Group: _____

Guarantor Information

First Name: _____ Last Name: _____

Sex: Male / Female **Date of Birth: _____** (MM/DD/YYYY)

Social Security: _____ Patient Relation: Spouse / Child / Other

Street Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Work Phone: _____

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Pharmacy Information

Name (Location): _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

Medication & Substance History

#	Name of Medicine	Dosage	#	Name of Medicine	Dosage
1			**6**		
2			**7**		
3			**8**		
4			**9**		
5			**10**		

Smoking Status: Never / Former / Recreational / Heavy

Sexual Orientation: Heterosexual / Homosexual / Bisexual / Decline to Specify

Drug Allergies: _____

Food Allergies: _____

Emergency Contact

Full Name: _____

Phone Number: _____

Email: _____

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Medical History

Please check or list any major illness in your family members. (Mother, Father, Brothers, Sisters, or Children)

- ☐ Tuberculosis
- ☐ Emphysema
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Osteoporosis
- ☐ Diabetes Mellitus
- ☐ Thyroid Disease
- ☐ Anemia
- ☐ Hemophilia
- ☐ _____
- ☐ Kidney Disease
- ☐ Epilepsy
- ☐ Neurological Disorder
- ☐ Liver Disease
- ☐ _____
- ☐ Breast Cancer
- ☐ Ovarian Cancer
- ☐ Colon Cancer
- ☐ Prostate Cancer
- ☐ _____

Please check conditions which you have had?

GENERAL
- ☐ Serious Infections (e.g. pneumonia) _____
- ☐ Diabetes Mellitus
- ☐ Rheumatic Fever
- ☐ HIV Infection
- ☐ Cancer (where?) _____

CVS
- ☐ High Blood Pressure
- ☐ Congestive Heart Failure
- ☐ Heart Murmur
- ☐ Heart Valve Disease
- ☐ Angina
- ☐ Heart Attack
- ☐ High Cholesterol
- ☐ Abnormal Heart Rhythm
- ☐ Blood Clots in Veins
- ☐ Blocked Arteries in Neck
- ☐ Blocked Arteries in Legs

HEENT
- ☐ Glaucoma
- ☐ Allergies "hay fever"
- ☐ Frequent Ear Infections
- ☐ Frequent Sinus Infections

RESPIRATORY
- ☐ Asthma
- ☐ Emphysema
- ☐ Blood Clots In Lungs
- ☐ Sleep Apnea

MUSCULOSKELETAL / EXTREMITIES
- ☐ Osteoporosis
- ☐ Rheumatoid Arthritis
- ☐ Degenerative Joint Disease
- ☐ Fibromyalgia
- ☐ Neck Pain (herniated disc)
- ☐ Back Pain (herniated disc)

LYMPHATIC / HEMATOLOGIC
- ☐ Thyroid Goiter
- ☐ Over Active Thyroid
- ☐ Under Active Thyroid
- ☐ Transfusions
- ☐ Anemia

GI / GU
- ☐ Stomach Ulcers
- ☐ Ulcerative Colitis
- ☐ Crohns Disease
- ☐ Bleeding from Intestines
- ☐ Diverticulitis
- ☐ Colon Polyps
- ☐ Irritable Bowel Disease
- ☐ Hepatitis
- ☐ Cirrhosis of the Liver
- ☐ Liver Failure
- ☐ Pancreatitis
- ☐ Gallstones
- ☐ Kidney Stones
- ☐ Kidney Failure
- ☐ Prostate Disease
- ☐ Endometriosis
- ☐ Sex Transmitted Infection

SKIN / BREAST
- ☐ Acne
- ☐ Eczema
- ☐ Psoriasis
- ☐ Fibrocystic Breast Disease

NEUROLOGIC / PSYCHIATRIC
- ☐ Chronic Vertigo (Meniere's)
- ☐ Peripheral Nerve Disease
- ☐ Migraine Headaches
- ☐ Stroke
- ☐ Multiple Sclerosis
- ☐ Depression
- ☐ Anxiety

Please indicate any surgeries you have had and the year you had them.

Year
- _____ Angioplasty
- _____ Carotid Artery Surgery
- _____ Other Vascular Surgery
- _____ Coronary Bypass Surgery
- _____ Chest / Lung Surgery
- _____ Tonsillectomy
- _____ Neurosurgery

Year
- _____ Trauma Related Surgery
- _____ Back or Neck Surgery
- _____ Hip Surgery
- _____ Knee Surgery
- _____ Carpal Tunnel Surgery
- _____ Sinus Surgery
- _____ Ear Surgery

Year
- _____ Stomach Surgery
- _____ Inguinal Hernia
- _____ Colonoscopy
- _____ Gallbladder
- _____ Appendectomy
- _____ Prostate Surgery
- _____ Bladder Surgery

Year
- _____ Tubal Ligation
- _____ C-Section
- _____ Hysterectomy
- _____ Ovary Removed
- _____ Breast Surgery
- _____ Thyroid Surgery
- _____ Other _____

Please indicate when you last had any of the following preventative tests or services.

Year
- _____ Cardiac Angiogram
- _____ Stress Test
- _____ Echocardiogram
- _____ Chest X-ray
- _____ EKG

Year
- _____ Flu Vaccine
- _____ Pneumonia Vaccine
- _____ Tetanus Vaccine
- _____ Hepatitis Vaccine
- _____ Bone Density Test

Year
- _____ Prostate Cancer Blood Test
- _____ Rectal Exam
- _____ Colon Cancer Stool test
- _____ Flexible Sigmoidoscopy
- _____ Barium Enema

Year
- _____ Mammogram / Breast Exam
- _____ Pap Smear
- _____ Date of Last Physical Exam
- _____ Other _____

Tobacco
- ☐ never ☐ past ☐ active
- ☐ cigarette ☐ cigar ☐ pipe
- ☐ snuff ☐ dip ☐ chewing
- Start _____ Stop _____
- packs per day _____

Alcohol
- ☐ never ☐ past ☐ active
- ☐ liquor ☐ wine ☐ beer
- ____ drinks per
- ☐ day ☐ week ☐ month
- ☐ AA ☐ Alcohol Rehab

Illicit Drugs
- ☐ never ☐ past ☐ active
- ☐ cocaine ☐ marijuana
- ☐ heroin ☐ amphetamine
- ☐ barbiturate ☐ LSD ☐ PCP
- ☐ IV Drug Abuse ☐ Drug Rehab

Caffeine
- ☐ never ☐ past ☐ active
- ☐ coffee ☐ tea ☐ soda
- _____ cans / cups per day

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Acknowledgment of Receipt: Mason Park Medical Clinic Agreements

Mason Park Medical Clinic reserves the right to modify the privacy practices outlined.
I have read and reviewed the "*Mason Park Medical Clinic Notice of Privacy Policies"*
I have read and reviewed the "Mason Park Medical Clinic Consent Form"
I have read and reviewed the "Mason Park Medical Clinic Authorization Form"

_____
Patient Name (Printed)

_____
Signature of Patient

_____
Guarantor Printed Name

_____
Representative Signature (If Patient a Minor)

_____ _____
Date (MM/DD/YYYY) *Representative Relation*

Request for Confidential Communication of Patient Protected Health Information

Below we will discuss the approved forms of contact regarding appointments, results, and or any other information regarding your treatment here at *Mason Park Medical Clinic;* as well as who is deemed an allowed person of communication regarding the above.

Approved Forms of Communication

Method of Communication	Yes	No
Phone Call		
Text Message		
E-Mail		

Approved Contacts

Person of Contact	Appointments	Results	Medication
Spouse			
Children			
Emergency Contact			

*Patients are responsible to inform *Mason Park Medical Clinic* of any changes to the above forms of communications and is not responsible for any costs regarding phone bills, text messages, and or other services provided by your cellular provider.