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		Year		Year		Year	
_____	Angioplasty	_____	Trauma Related Surgery	_____	Stomach Surgery	_____	Tubal Ligation
_____	Carotid Artery Surgery	_____	Back or Neck Surgery	_____	Inguinal Hernia	_____	C-Section
_____	Other Vascular Surgery	_____	Hip Surgery	_____	Colonoscopy	_____	Hysterectomy
_____	Coronary Bypass Surgery	_____	Knee Surgery	_____	Gallbladder	_____	Ovary Removed
_____	Chest / Lung Surgery	_____	Carpal Tunnel Surgery	_____	Appendectomy	_____	Breast Surgery
_____	Tonsillectomy	_____	Sinus Surgery	_____	Prostate Surgery	_____	Thyroid Surgery
_____	Neurosurgery	_____	Ear Surgery	_____	Bladder Surgery	_____	Other _____

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

Year		Year		Year		Year	
_____	Cardiac Angiogram	_____	Flu Vaccine	_____	Prostate Cancer Blood Test	_____	Mammogram / Breast Exam
_____	Stress Test	_____	Pneumonia Vaccine	_____	Rectal Exam	_____	Pap Smear
_____	Echocardiogram	_____	Tetanus Vaccine	_____	Colon Cancer Stool test	_____	Date of Last Physical Exam
_____	Chest X-ray	_____	Hepatitis Vaccine	_____	Flexible Sigmoidoscopy	_____	Other _____
_____	EKG	_____	Bone Density Test	_____	Barium Enema		

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.