IMPERIAL CARE INTERNAL MEDICINE

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HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

NAME/NOMBRE: (Last, First, M.I)	Male or Female
DOB/ FECHA DE NACIMIENTO:	
MARITAL STATUS /ESTADO CIVIL: Single/Soltero Partnered/Con pareja Married/Casado Separated/Divorciado Widowed/Viudo	

HEALTH HISTORY/ HISTORIA MEDICA	
Childhood Illness/Enfermedades de la infancia: ☐ Measles/Sarampion ☐ Mumps ☐ Rubella/Rubeola ☐ Chickenpox/Varicela ☐ Rheumatic fever/ Fiebre reumatica ☐ Polio	
Immunizations and dates/ Inmunizaciones y fechas:	
☐ Tetanus/Tetanos:	☐ Pneumonia/Neumonia:
☐ Hepatitis:	☐ Chickenpox/Varicela:
☐ Influenza:	☐ MMR Measles, Mumps, Rubella:

MEDICAL PROBLEMS THAT OTHER DOCTORS HAVE DIAGNOSED/ PROBLEMAS MEDICO QUE OTROS MEDICOS LO HAN DIAGNOSTICADO

SURGERIES / CIRUGIAS		
Year/Ano	Reason/Razon	Hospital

OTHER PROBLEMS/ OTROS PROBLEMAS		
___ Skin/Piel	___Chest/Heart/ pecho/Corazon	___Weight/ Peso
___Head/Neck Cabeza y cuello	___Back/ Espalda	___Energy level/ nivel de energia
___ Ears/ Oidos	___ Intestinal	___Ability to sleep/ Capacidad para dormir
___Nose/ Nariz	___Bowel/ Intestino	
___ Throat/ Garganta	___Bladder/ Vejiga	___ Other pain/discomfort/ otros dolores o molestias:
___Lungs/ Pulmones	___Circulation/ circulacaion	

PRESCRIBED DRUGS VITAMINS, AND OVER-THE-COUNTER DRUGS/ MEDICAMENTOS CON RECETA O DE VENTA LIBRES, VITAMINAS Y LOS INHALADORES		
Name the Drug/ Nombre **de Medicina**	Strength/**Fuerza** de medicina	**Frequency** Taken/ **Seguido** se toma

ALLERGIES TO MEDICATIONS/ ALERGIAS A MEDICAMENTOS	
Name of drug/ Nombre **de medicina**	Reaction **you had/** Reaccion que **tuvo**

Preferred Pharmacy

Local Pharmacy/Farmacia Local: _____

Mail Order/Orden de Correo: _____

HEALTH HABITS AND PERSONAL SAFTEY/ HABITOS DE SALUD Y SEGURIDAD PERSONAL				
Alcohol	**Do you drink alcohol?/** Toma **alcohol?**			YES **NO**
	If yes, what kind?/ Que tipo?			YES **NO**
	How many drinks per week?/ **Cuantas bebidas** por semana?			YES **NO**
	Are **you concerned** about the **amount you drink?/** Esta preocupado **por la cantidad que** bebe?			YES **NO**
	Have you considered stopping? **Ha pensado** en parar de beber?			YES **NO**
	Have you ever experienced blackouts?/ **ha tenido** Perdida del **conocimiento?**			YES **NO**
	Are **you prone** to "binge" drining?/ **Es usted** propenso a la borr**achera?**			YES **NO**
	Do you drive after drinking?/ **Maneja despues** de tomar?			YES **NO**
Tobacco/Tabaco	**Do you use tobacco/** Usa tabaco?			YES **NO**
	____ **Cigarettes** pks./day/ **Cigarrillos-cuantos**/dia	___Chew- **#/day** Masticar- **cuanto/dia**	___Pipe- **#/day** Pipa- **cuanto/dia**	___ Cigars- **#/day** Cigarros-cuanto/**dia**
	___ **# of years/** # de anos **de uso**	___ Or **year quit/ que** ano dejo de usar **tabaco?**		
Drugs/Drogas	**Do you currently** use recreational **or street drugs**?/ Utiliza Drogas **recreativas** o **de la calle?**			YES **NO**
	Have you ever given yourself st**reet drugs with** a needle?/ Alguna **vez te has** dado **Drogas de la** calle con una aguja?			YES **NO**

MENTAL HEALTH/ SALUD MENTAL		
Is stress a major problem for **you?/ Estres** es problema para **usted?**	YES	**NO**
Do you feel depressed?/ Se **siente deprimido**?	YES	**NO**
Do you panic when stressed?/ **entra en** panico cuando esta **estresado?**	YES	**NO**
Do you have problems with **eating or you** appetite?/ tiene **problemas con** comer o apetito?	YES	**NO**
Do you cry frequently? Llora **frequentemente**?	YES	**NO**
Have you ever attempted **suicide?/ Alguna** ves ha intenado **suicidarse?**	YES	**NO**
Do you have trouble sleeping?/ **Tiene dificultad** para dormir?	YES	**NO**
Have you ever been to a **counselor ?/ Aguna** vez has visto a **un consejero**?	YES	**NO**

FAMILY HEALTH HISTORY/ HISTORIA DE FAMILIA		
	AGE/EDAD	**IF ANY HEALTH PROBLEMS / Problemas de salud**
FATHER/PADRE		
MOTHER/MADRE		
SIBLINGS/ HERMANOS	**Male Female_____**	
	Male Female_____	
	Male Female_____	
CHILDREN/ HIJOS	**Male Female_____**	
	Male Female_____	
	Male Female_____	
GRANDMOTHER (MATERNAL/PATERNAL)		
GRANDFATHER (MATERNAL/PATERNAL		

PATIENT INFORMATION/ INFORMACION DE PACIENTE

Ethnicity / Etnicidad- Race
__ **Hispanic or Latino**
__ **White**
__ **American Indian/ Alaska Native**
__ **Asian/ Asiatico**
__ **Black or African American**
__ **Native Hawaiian**
__**Other**

Primary language spoken/**Primer idioma**:		**Secondary Language**:
Address/ Direccion:		Phone **number**:
City/Ciudad:	**State/** Estado:	Zip **Code/ Codigo** Postal:
Occupation/ Occupacion:	**Employer/** Empleado:	

☐ By checking this box, I consent to receive test messages related to appointment reminders, follow up messages, billing inquiries, scheduling, and updates from Imperial Care Internal Medicine. You can reply "Stop" at any time to opt-out. Message and data rates may apply. Message frequency may vary, text HELP to 903-957-0417 for assistance. For more information, please refer to our privacy policy and SMS Terms and Conditions on our website at https://imperialcareinternalmedicine.com/

_____**CONSENT** TO MEDICAL CARE **AND TREATMENT** I am being **treated at ("Physician** Office/Clinic"), **and I consent** to all medical and **surgical care, examinations** and test **determined by my** physician that are **necessary for me**. Though I except **the care given** will meet customary **standards, I understand** there are no guarantees **concerning** the results of my **care. I also understand** that if I do **not follow my** physician's recommendations **as they may relate** to my health the **physician and** this office will not be **responsible** for any injuries or **damages that are** a result of my non-**compliance. I** understand that if **an employee or** any individual **associated with the** physician's office **is exposed to** my blood or body **fluid, I will be tested for the** hepatitis viruses **and the Human** Immunodeficiency **Virus (HIV). I** also understand that **I will receive** education related to **this testing and that I will** be charged for both **testing and** education related to **the exposure**

_____**CONSENT** TO USE INFORMATION Electronic Health Records. **I understand** that the Physician **Office may collaborate** with other **health care providers to** coordinate, manage, **and provide** health care to me **and I consent to the** Physicians Office's **sharing my** health information **and records electronically** for the purpose of **treatment, payment** and/ or operations, **including** the over all quality **health care** services provided to **me. I consent to the** inclusion in the **electronic health** records of sensitive **diagnoses and** related information **such as HIV/AIDS** status, sexually **transmitted** diseases, genetic **information, and** mental health and **substance abuse**, etc. The Physicians **Office has** implemented **administrative, physical, and** technical safeguards **that reasonably** and appropriate **protect and** confidentiality and **integrity of my** medical information **as required by HIPAA.**

Use and Disclosure of Information. **In addition** to the above consent **to use and** share my health **information, I agree** that the Physician **Office may use and disclose** my health information **for a range** of purposes **including: treatment**, eligibility, **verification, and/or** payment to private **and public payers, including** insurance companies, **managed** care organizations, **my employer** (if I am injured at **work), state** and federal government **programs, Worker's** Compensation **programs, obtaining** pre admission **or continued** length of stay **certification, quality** of care assessment **and improving activities**, evaluating **the performance** of qualifications **of physicians** and healthcare workers, **conducting** medical and nursing **training and education** programs, conducting **or arranging** for medical review, **adult services**, ensuring compliance **with legal**, regulatory ad **accreditations requirements** and public health **oversight services.**

Request for Information from others. **I consent to** the Physicians **Office request of** my health information **from other** providers providing **care to me, receipt of** and release of my **health information**, whether written, **verbal or electronic**, for the **uses described** above as well as by **Physicians Office participation** in any health **information exchange** described **in the Physician** Office's Notice **of Privacy Practices** (NPP). Please **refer to the NPP for Additional**, detailed Information **regarding the uses** and disclosures **of protected** health Information.

_____ **ASSINGMENT OF BENEFITS I herby assign** to and authorize **payment of all** insurance and **health care benefits** available to me **directly to the Physician's Office** for services **provided to me.** I understand that **the benefits may** be payable to me **directly if I do** not provide this **authorization.**

_____ **FINANCAIL RESPONSIBILTY I understand and agree** that I am **financially responsible** for payment **of all charged** incurred which **are not paid by insurance of** health care benefits, **including any** and all products **provided and/or** services rendered **to me which are** not eligible for payment **(non-covered)** under health care **plans, Medicare,** Medicaid or other **insurance or** payers **(e.g., services rendered by** healthcare providers **who do not participate** with my Insurance **plan). Non-covered** services **also may include** those services my **physician determines** to be medically **necessary, but are later** determined unnecessary **by the payer.**

_____ **PHARMACY BENEFITS MANAGERS I understand** and agree **that IMPERIAL CARE** INTERNAL MEDICINE **can request** and use **prescription medication** history from other **health care providers** and/or third-**party pharmacy** benefit payors **for treatment purposes.**

_____ **PEROSONAL VALUABLES I understand that** the Physician's **Office does not** accept responsibility **for any lost,** stolen, and/or damaged **personal items** while
I **am at the** Physician's Office.

_____ **OFFICE POLICIES** As a **patient of IMPERIAL** CARE INTERNAL **MEDICINE I** understand payment **is due at time** services are rendered, **unless prior payment** arrangements re **made with the** office, this includes **any deductible,** copayment or **co-insurance amount.** Any balances **not paid by my insurance** carried are my **responsibility to** resolve. I further **understand that** balances due must **be paid in a timely** manner to avoid **further collection action.** I understand **is my account if** forwarded to a **collection agency I** may be dismissed **from the practice;** my outstanding **balance may be reported to** the credit bureau **and my balance** may be charged **an 18% interest** rate per year **until balance is revolved.** I am to present **proof of my insurance** coverage at ***EVERY*** **office visit. I UNDERSTAND IF I AM MORE THAN 15 MINUTES LATE FOR MY SCHEDULED** APPOINMENT **I MAY BE ASKED TO RCHEDULE** APPOINTMENT **I MAY BE ASKED TO RESHELDULE FOR ANOTHER DAY.** Finally, **I understand** that I am to allow at **least 48 hours for my** prescription refills.

RELEASE INFORMATION

I give my permission for the **office staff to** leave a message **on my answering** machine **regarding:**

___ **Appointment** reminders ___ Test results

___ **Request** for return phone **call** ___No answering **machine** available or permission **not given**

I give permission for the office **staff to speak** to: Name: _____

. Phone **number:** _____