Medical History Form
formulario de historia medicos

Your answers on this form will help your clinician understand your medical concerns and conditions. Best estimates are fine if you cannot remember specific details. / Sus respuestas en este formulario le ayudará a su médico entender sus problemas médicos y condiciones. Las mejores estimaciones indican muy bien si usted no puede recordar detalles específicos.

PERSONAL INFORMATION / Información Personal:

Patient's First Name: _____ Middle Name: _____
Primer Nombre del paciente Segundo nombre

Maiden Name (dad's last name): _____ Last Name (married name): _____
apellido (el apellido del papá) apellido(de casada)

Home phone: _____; cell phone _____ work phone _____
Teléfono de casa Teléfono cellular Teléfono de trabajo

Address: _____ City, State, Zip: _____
Dirección: Codigo Postal

Date of Birth: _____ Age: _____ Sex: Female - Male Country of Birth: _____
Fecha de nacimiento Edad Sexo Mujer - Hombre Donde Nacio

Social Security Number: _____ Medicaid/Medicare #: _____ Número de Seguro Social
Número de Medicaid/Medicarel

Email Address: _____
correo electrónico

Do you have Medicare / Medicaid or Private Insurance? / ¿Tiene usted Medicare / Medicaid o Aseguaranza Privada?

☐ No ☐ Yes / si …. If yes, Insurance carrier's Name:Si contesto que si: _____
Policy #:/ numero de póliza: _____ Group # / numero de grupo: _____
Insured's Name/nombre del asegurado: _____
relationship to patient/ parentesco con el paciente: _____

If patient is a minor, parent's name: _____
Si paciente es menor firmar los padres

Preferred Language/ Idioma: English/Inglés Spanish/Español German/Alemán Other,explain/orto,explique: _____

Employed by: _____ Occupation / Ocupación: _____
Empleado por

Spouse/Partner's Name / Nombre pareja's o conyuge: _____

Spouse employed by: _____ Occupation / Ocupación: _____
Empleador de su cónyuge

Number of people living in your home: Number of Adults: _____ Number of Children _____
Numero de personas ue viven ens casa: Numbero de Adultos: Número de hijos:

Emergency Contact _____ _____
Contacto de Emergencia: Name/Nombre Relationship/Relación

Home phone: _____; cell phone _____ work phone _____
Teléfono de casa Teléfono celular Teléfono de trabajo

Marital status / Estado civil:
☐ Single/soltero ☐ Married/Casado
☐ Separated/Separad ☐ Divorced/Divorciado
☐ Widow/Viuda ☐ Co-habiting/co-habitando

Education completed / educación completada –
☐ Grade school/grado de escuela
☐ High school/secundaria
☐ College/Colejo

Ethnic Background / Origen étnico –
☐ Hispanic/Hispano
☐ Black/Negro
☐ White/Blanco
☐ Asian/Asiático
☐ Native American /nativos americanos

SURGICAL HISTORY (Please list all prior operations and dates)**:**
Antecedentes quirúrgicos (por favor lista de todas las operaciones anteriores y las fechas)

Operation / *Operación:* _____ Date / *Fecha*_____

Operation / *Operación:* _____ Date / *Fecha*_____

☐ I have had no prior surgery. / *He tenido ninguna cirugía previa.*

MEDICATIONS: / Medicamentos:
Prescription and non-prescription medicines, vitamins, home remedies, birth control pills, & herbs.
Con receta y medicamentos de venta libre, vitaminas, remedies caseros, pildoras anticonceptivas, hierbas.

☐ I take no regular medications/No tomo medicamentos regulares.

Medication / Medicamentos	Dose/Dosis	Times per day/Veces al dia

ALLERGIES or REACTIONS to MEDICINES / FOODS / VACCINATIONS / OTHER AGENTS:
Alergias o reacciones a los medicamentos / Alimentos / Otros agents:

Reaction or Side Effect / *Reacción o efecto secundario*	Medication / *Medicamentos*

☐ I am not allergic to any medications. / *No soy alérgica a algún medicamento*

Tobacco Use:
uso de tabaco:

☐ Never Smoked / nunca he fumado

☐ Currently smoke _____ pack(s) /day, # of yrs. _____ / yo actualmente fumo _____ paquete(s) / día, # de anos. _____

☐ I quit smoking in _____ / he dejado de fumar. Fecha que paro: _____

Other Tobacco:
Otros Tabaco:

☐ Pipe / pipa ☐ Cigar / cigarro ☐ Snuff / holer ☐ Chew / mastique

Alcohol Use:
consume de alcohol:

Do you drink alcohol? / ¿ Bebe alcohol? ☐ No ☐ Yes / si

Average # drinks / week: / promedio bebidas # / semana:

_____ 5 oz. glasses wine / 5 oz. vasos de vino

_____12 oz. Cans beer / 12 oz. latas de cerveza

_____ 1.5 oz. Shots hard liquor / 1.5 oz. licor duro

Drug Use:
El us de drogas:

Do you use any recreational drugs? / ¿ *utilize alguna dioga illegal*? ☐ No ☐ Yes / si

Have you ever used needles? / / ¿ *Alguna vez haz utilizado agujas?* ☐ No ☐ Yes / si

Dental Care:
Cuidado Dental:

Do you see a dentist on a regular basis? / ¿ *Visita el dentist regularments?* ☐ No ☐ Yes / si

FAMILY HISTORY / Antecedentes Familiares:

Please indicate with a check (✓) family members who have had any of the following conditions:
Por favor, indique con una marca (✓) los familiars que han tenido alguna de las siguientes condiciones:

☐ **I do not know my family history.** / No sé mi historia familiar.

Medical Condition / Condición Medica	Patient Paciente	Mom Mamá	Dad Papá	Sister Hermana	Brother Hermano	Daughter Hija	Son Hijo
Acid Reflux **/** acido reflujo							
Alcoholism / Alcoholismo							
Anemia / Anemia							
Anxiety **/** anciedad							
Arthritis / Arthritis							
Asthma / Asma							
Birth Defects / defectos de nacimiento							
Bleeding problem / problema sangrado							
Cancer-Type_____ Date: _____ cancer –especificar el tipo fecha							
Bowel Problems/Polyps / problemas de intestinos/pólipos							
COPD **/** problemas respiratorio							
Depression / depresión							
Diabetes, Type 1 or 2 / diabetes, tipo 1 o 2							
Eczema/Skin Problems / eccema/problemas de la piel							
Epilepsy (seizures) / epilepsia (convulsions)							
Glaucoma/Vision / glaucoma/vista							
Hay Fever (allergies) / fiebre (alergias)							
Hearing Problems / problemas de oido							
Heart Problems / problemas del corazon							
High Blood Pressure / presión alta							
High Cholesterol / colesterol alto							
HIV / Hepatitis C / VIH / Hepatitis C							
Kidney diseases / enfermedad del riñon							
Lupus (SLE) / lopus (SLE)							
Mental retardation / retardación mental							
Migraine Headaches / migraña dolor de cabeza							
Mitral Valve Prolapse / Prolapso de la válvula mitral							
Osteoarthritis / Osteoartritis							
Osteoporosis / Osteoporosis							
Psychiatric disorders / desorden psychiatrico							
Rheumatoid Arthritis / reumatosoide artritis							
Seizures / Sirugias/							
Stroke (CVA) / golpe (CVA)							
Thyroid disorders / desorden tiroide							
Tuberculosis / tuberculosis							

GENERAL CONSENT AND DISCLOSURE
CONSENTIMIENTO GENERAL Y DIVULGACIÓN

The information in this consent form is given so that you will be better informed about the health care services you will receive. After you are sure you understand the information which will be given about the services and, if you agree to receive the services, you must sign this form to indicate that you understand and consent to the services. / La información de este formulario de consentimiento se da de modo que usted estará mejor informado acerca de los servicios de atención médica que recibirá. Después de que esté seguro de entender la información que se dará sobre los servicios y, si usted se compromete a recibir los servicios, usted debe firmar este formulario para indicar que entiende y acepta los servicios.

NOTIFICATION: Paris-Lamar County Health Department (hereafter called the Department) encourages individuals to seek a personal physician for periodic health examinations and for treatment of health problems. The Department clinic services are targeted primarily toward prevention of health problems amount those who cannot access a physician. The Department cannot assume the responsibility for payment of medical care received outside this clinic, including the delivery of babies, unless previous authorization has been given. / NOTIFICACIÓN: París-Lamar County Health Department (en adelante, el Departamento) incite a las personas a buscar un médico personal para los exámenes periódicos de salud y para el tratamiento de problemas de salud. Los servicios de la clínica del Departamento se dirigen principalmente hacia la prevención de problemas de salud cantidad aquellos que no pueden acceder a un médico. El Departamento no puede asumir la responsabilidad del pago de la atención médica recibida fuera de esta clínica, incluyendo la entrega de los bebés, salvo autorización previa se ha dado.

DISCLAIMER ON SCREENING: Among its services, the Department utilizes screening tests, which are a method of identifying individuals who are at risk for developing several common medical problems. In this way they can alert you to promptly seek medical evaluation and treatment from a private physician of your choosing. Screening tests perform valuable service in helping to find certain diseases early in their course. However, these screening tests do not cover all diseases, and they may miss some cases of diseases they are intended to find. They are not diagnostic and they do not constitute a complete exam. / RENUNCIA DE PROYECCIÓN: Entre sus servicios, el Departamento utiliza exámenes de revisión, que son un método de identificación de las personas que están en riesgo de desarrollar varios problemas de salud comunes. De esta manera, puede avisarle a buscar sin demora una evaluación médica y el tratamiento de un médico privado de su elección. Las pruebas de detección realizar el servicio valioso para ayudarlos a encontrar ciertas enfermedades temprano en su curso. Sin embargo, estas pruebas de detección no cubren todas las enfermedades, y pueden pasar por alto algunos casos de enfermedades que están destinados a encontrar. Ellos no son diagnósticos y no constituyen un examen completo.

GENERAL CONSENT: I give my permission to the Department, its designated staff and other medical personnel providing services under its sponsorship to perform physical assessments or examinations, conduct laboratory or other tests, give injections, medications, and other treatments, injectable medication for sexually transmitted diseases, family planning methods, HIV testing, and render other health services to the patient identified on this form. / CONSENTIMIENTO GENERAL: Doy mi permiso al Departamento, el personal designado y otro personal médico que ofrecen servicios bajo su patrocinio para llevar a cabo las evaluaciones o exámenes físicos, de laboratorio o realizar otras pruebas, poner inyecciones, medicamentos y otros tratamientos, medicamentos inyectables para la transmisión sexual enfermedades, métodos de planificación familiar, pruebas de VIH, y hacer otros servicios de salud para el paciente identificado en esta forma.

PHOTOGRAPH CONSENT: I give my permission to the Department, its designated staff and other medical personnel providing services under its sponsorship to interview, photograph, televise, film, or record my appearance, utterances and/or behavior. / FOTOGRAFÍA CONSENTIMIENTO: Doy mi permiso al Departamento, a su personal designado y otro personal médico que ofrecen servicios bajo su patrocinio para entrevistar, fotografiar, televisar, el cine, o constancia de mi apariencia, expresiones y / o comportamiento.

INFORMED CONSENT: In addition to the above general consent, I understand that special informed consent forms must be read and signed for the following procedures: medications for tuberculosis and Hansen's disease, immunizations, PKU special counseling, and certain other things. / CONSENTIMIENTO INFORMADO: Además de la autorización general que antecede, entiendo que las formas especiales de consentimiento informado debe ser leída y firmada por los procedimientos siguientes: medicamentos para la tuberculosis y la enfermedad de Hansen, vacunas, asesoramiento PKU especiales, y algunas otras cosas.

PRIVACY NOTICE: I acknowledge that I have received a copy of the Department's HIPAA Privacy Notice. / AVISO DE PRIVACIDAD: Reconozco que he recibido una copia de HIPAA Aviso de privacidad del Departamento.

QUESTIONS: I certify that this form has been fully explained to me, that any blank lines have been filled in and that any questions I have had about the services have been answered to my satisfaction. / PREGUNTAS: Certifico que este formulario ha sido plenamente explicado a mí, para que todas las líneas en blanco han sido llenados y que cualquier pregunta que he tenido acerca de los servicios han sido contestadas a mi satisfacción.

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SECTION I:
Patient's Printed Name____________________________ Patient's Signature (X) ___________________________________ Date: _____________________
Nombre de paciente Firma de paciente Fecha

Person Authorized to Consent Signature (X) _____________________________________ Relationship: _____________ Date: ___________________
Firma de autorizar Relacion Fecha

SECTION II:

Counselor's Signature (X) ____ Date: ____________________________________

TWO (2) YEARS AFTER the above date of signature, then please complete this section.

SECTION III:
Patient's Printed Name______________________________ Patient's Signature (X) __________________________________ Date: ___________________
Nombre de paciente Firma de paciente Fecha

Person Authorized to Consent Signature (X) _____________________________________ Relationship: ______________ Date: _________________
Firma de autorizar Relacion Fecha

SECTION IV:

Counselor's Signature (X) ____ Date: _________________________________
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Paris–Lamar County Health District
400 West Sherman Street, Paris, Texas 75460-5646
Health District: (903) 785-4561
Health District Fax: (903) 737-0978
Women, Infant and Children (WIC): (903) 784-1411
WIC Fax: (903) 784-1442
www.parislamarhealth.com

Medical Information Release Form by Client
(HIPAA Release Form)
Revised 10/1/2014

Forma para compartir información médica del Cliente
(Forma para compartir información HIPAA aviso de privacidad)
revisada 01/10/2014

Name: _____ Date of Birth: ____/____/____
Nombre *Fecha de nacimiento*

Release of Information / *compartir información*

☐ I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to: /
Yo authorize que compartan información, incluyendo el diagnóstico, recors, exámenes hacerca de mi E información de Reclamos. Esta información puede ser compartida a:

- ☐ Spouse / *Esposa* _____
- ☐ Child(ren) / *hijo (s)* _____
- ☐ Other / *otro* _____
- ☐ Information is not to be released to anyone. / *La información no puede ser compartida a nadie.*

This Release of Information will remain in effect until terminated by me in writing. /
Esta authorización para compartir información permanecera en vigor hasta que yo la termine por escrito.

Messages - Please call / *Mensaje – Por favor habla*

- ☐ my home #:/ *mi casa* _____
- ☐ my work #:/ *mi trabajo* _____
- ☐ my cell #: / *mi numero cellular* _____

If unable to reach me: / *Si no me puedes contactar*

- ☐ you may leave a detailed message / *puedes dejar un mensaje de tallado*
- ☐ please leave a message asking me to return your call / *por favor deja un mensaje pidiendome que te davuelva la llamada.*
- ☐ _____

The best time to reach me is (day) _____ between (time) _____ & _____
El major momento para contactarme es (dia) _____ *entre (hora))*_____ *&* _____

Signed: _____ Date: ____/____/____
Firma *Fecha*

Witness: _____ Date: ____/____/____
Testigo *Fecha*

Complete this page if patient is under the age of 19

Child Health History

PREGNANCY AND BIRTH
G _____ P_____ AB_____
Total number of living children _____ weight gain/loss _____
Mother's age at birth_____
Number of years between previous pregnancy and this child _____
Trimester Prenatal Care Began: 1 2 3
Prenatal Care Provider: _____
Vitamins: _____Y _____N Iron: _____Y _____N
If child over 5 years: uncomplicated pregnancy, labor, delivery and
Nursery course: _____Y _____N*
*If yes, proceed with Child's Medical History.

MATERNAL COMPLICATIONS

_____ Vaginal Bleeding
_____ Anemia
_____ Hypertension
_____ Rh negative
_____ Diabetes
_____ Premature labor
_____ Dental Disease
_____ Flu-like illness or high temp.
_____ Kidney or bladder infection
_____ STDs
_____ Hepatitis (A,B, or C)
_____ Exposure to TB
_____ Exposure to lead/chemicals
_____ Injury / hospitalization / surgery

MATERNAL SUBSTANCE USE

_____ OTC meds _____
_____ Prescription meds _____
_____ Tobacco _____
_____ Alcohol _____
_____ Street Drugs _____
_____ Caffeine _____

FAMILY MEDICAL HISTORY

HIV + individual in household _____Yes _____ No
(do NOT identify)

Abbreviations for relatives listed below.

M – Mother
F – Father
S – Sibling
MGM – Maternal Grandmother
MGF – Maternal Grandfather
MA – Maternal Aunt
MU – Maternal Uncle
PGM – Paternal Grandmother
PGF – Paternal Grandfather
PA - Paternal Aunt
PU – Paternal Uncle

_____ Anemia / blood disorder
_____ Heart disease before age 50
_____ Cholesterol req. treatment
_____ Hypertension / stroke
_____ Asthma / allergy
_____ Cancer
_____ Diabetes
_____ Epilepsy / seizures
_____ Kidney problems
_____ Muscle / bone disease
_____ Genetic disease or major birth defects
_____ Childhood hearing impairment
_____ Tuberculosis
_____ Other immunosuppression
_____ Dental decay
_____ Alcohol / drug abuse
_____ Tobacco use
_____ Learning disorder
_____ Mental retardation
_____ Psychiatric disorder
_____ Physical / sexual / emotional abuse
_____ Domestic violence
_____ Other *

Explanation / * Other:: _____
_____

Date: _____

Signature: _____ **Title:** _____

CLIENT INFORMATION
Name: _____
DOB: _____/_____/_____ Age: _____ Sex: _____
SSN / Record No.: _____
Race / Ethnicity: _____
Informant / Relationship: _____
Medical Home: _____

BIRTH / DELIVERY
Place of birth: _____
Birth attendant: _____
Hours of labor: _____

_____ Term
_____ Premature (Weeks) _____
_____ More than 2 weeks overdue

Type of Delivery:

_____ Vaginal
_____ C-Section
_____ Forceps

Complications:

_____ Breech
_____ Multiple birth
_____ Other *

Explanation / * Other:: _____
_____

NURSERY COURSE
Birth Weight: _____ Birth Length: _____ FOC: _____

_____ Difficulty with initial breathing
_____ Heart murmur
_____ Infection
_____ Transfusion
_____ Jaundice req. treatment
_____ Seizures

Age at discharge: _____ ICN _____ days

Newborn blood screening (data / location):
1. _____
2. _____

Newborn hearing test (in hospital): _____ Normal _____ Abnormal
Type of test: _____ ABR _____ OAE _____ Unknown
Referral made: _____ Yes _____ No
Comments: _____
_____

CHILD'S MEDICAL HISTORY
Immunizations current: ____ Yes _____ No _____ Record unavailable
Dental care / sealant current: _____Yes _____ No

_____ Trauma / injuries
_____ Hospitalizations
_____ Hepatitis
_____ Strep throat
_____ Bladder / kidney infections
_____ Seizures
_____ Hearing problems
_____ Anemia
_____ Asthma
_____ Surgery
_____ Eczema
_____ Ear Infections
_____ Pneumonia
_____ Vision problems
_____ Allergies
_____ Medications
_____ Environmental toxin exposure (lead, etc.)
_____ Early childhood caries
_____ Developmental delays
_____ Substance use (alcohol, drug, tobacco)
_____ Other

Explanation / * Other:: _____
_____

Date: _____

Signature: _____ **Title:** _____

Complete ONLY the gray areas in this section about the patient.
Completar solamente las areas en gris en esta sección sobre el paciente.

First Name/Primer Nombre: _____ Middle Name/Segundo nombre: _____

Maiden Name (Dad's Last Name)/: _____ Last Name (Married Name)/: _____
Apellido (el apellido del papa) Apellido (de casada)

DOB: _____ Pharmacy: _____
Fecha de nacimento Farmacia

Allergies: _____
Alergias:

To be completed by Medical Staff ONLY. / Ser completado solamente por el personal.

Treatment / Medication History Log

Date	Medication	Dose	SIG	Qty	# Refills	Refill Dates						D/C Date

Complete ONLY the gray areas in this section about the patient.
Completar solamente las areas en gris en esta sección sobre el paciente.

First Name/Primer Nombre: _____ Middle Name/Segundo nombre: _____

Maiden Name (Dad's Last Name)/: _____ Last Name (Married Name)/: _____
Apellido (el apellido del papa) Apellido (de casada)

DOB: _____

To be completed by Medical Staff ONLY. / Ser completado solamente por el personal.

Diagnoses / Problem History Log

Date	Problem #	Diagnoses / Problem

Date:	Problem #	CONSULTANT	Date	PROCEDURES / LAB	SIG:

IMMUNIZATIONS:				PHYSICAL EXAMS / PAPS:	
ImmTrac #:_____		Twices #: _____		Date:	Results:
Date:	Description:	Date:	Description:		

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Paris–Lamar County Health District
HIPAA/CONFIDENTIALITY STATEMENT

The Paris-Lamar County Health District is commitment to preserving the confidentiality and security of health information, whether it is maintained or distributed in paper, electronic, video, verbal or any other medium or format. The staff of the Paris-Lamar County Health District understands that if they have access to such health information, they are required to maintain its privacy, confidentiality and security.

Access to confidential information is permitted only on a need-to-know basis and is limited to the minimum amount of confidential information necessary to accomplish the intended purpose of the use, disclosure, or request.

Any violations of this policy may constitute grounds for disciplinary action up to and including termination of employment. Unauthorized use or release of confidential information may also subject the violator to personal, civil and/or criminal actions.

Violations of the Privacy Policies of PLCHD include (but are not limited to) the following:

- Accessing confidential information that is not within the scope of your duties
- Misusing, disclosing without proper authorization, or altering confidential information
- Disclosing to another person your sign-on information and/or password for accessing electronic confidential information or for physical access to restricted areas
- Using another person's sign on information and/or password for accessing electronic confidential information or for physical access to restricted areas
- Intentional or negligent mishandling or destruction of confidential information
- Attempting to access a secured application or restricted area without proper authorization or for purposes other than official PLCHD business

Any known or suspected violation of the confidentiality or security of health information must be reported soon as possible.

Client's Copy