Connie Pham, M.D., P
7850 Parkwood Circle Drive, Suite A-7 Houston,
Tel. (346) 220-6388 Fax. (346) 220-6

PATIENT INFORMATION DATE: _____

Name _____ _____ Social Security No. _____
(First name) (Last name)

Date of birth _____ Age _____ Sex ☐ Male ☐ Female

Marital status ☐ single ☐married ☐separated ☐divorced ☐widowed

Address _____ City _____ State _____ Zip _____

Phone (home) _____ (cell) _____ (work) _____

Email _____

Spouse's name (parent's name, if child) _____

Pharmacy name/number _____ Pharmacy address _____

How did you hear about us? ☐Banner ☐newspaper ☐radio ☐Internet ☐other

Employer _____ Occupation _____

Emergency contact _____ Relationship _____ Phone _____

SOCIAL HISTORY

Education Level:

Use of Tobacco: ☐Never ☐How much? _____ ☐# of years: _____ ☐Quit for _____ years

Use of Alcohol: ☐Never ☐How much? _____ ☐# of years: _____

Use of Street Drugs: ☐Never ☐If yes, describe: _____

Physical Activities: ☐Yes ☐No ☐If yes, # of times per week: _____ ☐Limited due to: _____

Any religious/cultural practices that would affect your care: _____

ALLERGIES

Allergies or reactions to food or medication:

_____
_____
_____

NAME	DATE OF BIRTH

HISTORY OF PAST ILLNESS

PERSONAL		VACCINATIONS		If yes, date:
Cancer	☐Yes ☐No	Influenza / Flu	☐Yes ☐No	
Diabetes	☐Yes ☐No	Pneumovax	☐Yes ☐No	
Heart Disease	☐Yes ☐No	Tetanus (Td or DTP)	☐Yes ☐No	
High Blood Pressure	☐Yes ☐No	Zoster or Shingles Vaccine	☐Yes ☐No	
Stroke	☐Yes ☐No	Hepatitis A (2 vaccines in 6 months)	☐Yes ☐No	
Lung Disease	☐Yes ☐No	Hepatitis B (3 vaccines in 6 months)	☐Yes ☐No	
Asthma	☐Yes ☐No	Typhoid	☐Yes ☐No	
Renal Disease	☐Yes ☐No	HPV (3 vaccines in 6 months)	☐Yes ☐No	
Glaucoma	☐Yes ☐No	Yellow Fever	☐Yes ☐No	
Anemia or Blood Disease	☐Yes ☐No	MMR	☐Yes ☐No	
Seizures or Convulsions	☐Yes ☐No	Chicken Pox	☐Yes ☐No	
Cholesterol	☐Yes ☐No	Polio	☐Yes ☐No	
Sleep Apnea	☐Yes ☐No	PPD or tuberculosis skin test	☐Yes ☐No	
Mental Illness	☐Yes ☐No	PPD result: ☐Negative ☐Positive Date of result: _____		
Other _____		Other _____		

HEALTH MAINTENANCE AND PROCEDURES

Have you ever had?		If yes, date:	Was the result normal:	If results are NOT normal, explain:
Colonoscopy	☐Yes ☐No		☐Yes ☐No	
EGD or Upper endoscopy	☐Yes ☐No		☐Yes ☐No	
Treadmill stress test (TMST)	☐Yes ☐No		☐Yes ☐No	
Nuclear treadmill stress test	☐Yes ☐No		☐Yes ☐No	
Echocardiogram (Echo)	☐Yes ☐No		☐Yes ☐No	
Angiogram	☐Yes ☐No		☐Yes ☐No	
Mammogram	☐Yes ☐No		☐Yes ☐No	
PAP Smear	☐Yes ☐No		☐Yes ☐No	
Bone density or DEXA	☐Yes ☐No		☐Yes ☐No	
Other _____ ___				

NAME	DATE OF BIRTH

PAST MEDICAL HISTORY

Prior Hospitalization	☐Yes ☐No	If yes, date:	Reason for Hospitalization
Prior Surgery	☐Yes ☐No	If yes, date:	Reason for Surgery

MEDICATION

Name of Medicine	Start Date	Dose	Frequency per Day

FAMILY HISTORY (check appropriate box)

Does your family member have any of the below conditions?

	Age	Alive	Deceased	Healthy	Diabetes	Hypertension	Heart Disease	Lung Dz	Stroke	Cancer	Other (Pls. specify)
Father											

Mother											
☐Daughter ☐Son											
☐Daughter ☐ Son											
☐Daughter ☐Son											
☐Daughter ☐Son											
☐Brother ☐Sister											
☐Brother ☐Sister											
☐Brother ☐Sister											
☐Brother ☐Sister											
Relative											
Relative											
Relative											

NAME	DATE OF BIRTH

REVIEW OF SYSTEM

	Check any that apply or "none"
Neuro	☐None ☐ Headache ☐Convulsions ☐Seizures ☐fainting ☐ADD ☐Stroke ☐Other
Psych	☐None ☐Depression ☐Anxiety ☐Stress/Excess Worry ☐Drug/alcohol Issues ☐Other
Eyes	☐None ☐Visual Problems ☐Blurry Vision ☐ Red Eyes ☐Eye Pain ☐Other
Nose	☐None ☐Nasal Allergies ☐Chronic Sinusitis ☐frequent ☐nose bleed ☐Other
Ears	☐None ☐Hearing problems ☐Ringing in the ears ☐discharge ☐Other
Throat	☐None ☐Swallowing difficulty ☐frequent sore throats ☐Speech problems ☐Other
Mouth	☐None ☐dental problems ☐tongue problems ☐Canker sores ☐Other
Neck	☐None ☐Swollen glands ☐Thyroid problems ☐Other
Chest	☐None ☐Chest pain ☐Asthma ☐shortness of breath ☐Chronic cough ☐+ TB Test ☐Other
Heart	☐None ☐Murmurs ☐Palpitations ☐ Valve problems ☐Mitral Valve problem ☐ Angina ☐Other
Intestinal	☐None ☐Heartburn ☐Reflux ☐Colitis + Gastritis ☐Polyps ☐Constipation ☐Bleeding ☐Other
Urinary & Genital	☐None ☐ Frequency ☐Burning ☐Kidney Stones ☐Infection or STD Erectile dysfunction ☐Urinary stream
Extremity and spine	☐None ☐Pain in: ☐arm ☐ wrist/hand ☐shoulder ☐ankle ☐neck ☐mid back ☐herniated disk
Systemic	☐None ☐Weight loss ☐fever ☐Night sweats ☐Trouble sleeping ☐Loss of energy ☐Arthritis

CONSENT TO MEDICAL TREATMENT

I hereby authorize Connie Pham, M.D., PLLC, its employees, agents and otherwise affiliates to administer any treatment, and perform such other actions as the physician may deem necessary or advisable in my diagnosis and treatment. I am aware that the practice of medicine is not an exact science and I acknowledge that no warranty, guarantee or assurance has been made by the clinic or physician as to the results of the treatments, examination or otherwise that may be obtained.

ASSIGNMENT OF INSURANCE BENEFITS TO PROVIDER

I hereby request payment and assign any benefits due me under the terms of any policy or policies and/or under Title XVIII of the Social Security Act that may cover professional services rendered to the above name mentioned assignee.

FINANCIAL AGREEMENT

I agree to pay any balance of the charges over and above the above mentioned benefits. It is understood by the undersigned that he/she is financially responsible for charges not covered by this assignment.

AUTHORIZATION TO RELEASE INFORMATION

I authorize the release of any information to any insurance company or third party payor for the purpose of obtaining payment for services provided. I authorize release of any information to any physician, skilled facility or other healthcare facility to which I may be admitted or that is involved in my medical care.

PATIENT / RESPONSIBLE PARTY SIGNATURE:	DATE: