MEDICAL HEALTH HISTORY QUESTIONNAIRE

Information provided on this form will assist your health care provider to better understand you medical conditions and concerns. All questions are optional and will be kept confidential.

Main reason for today's visit: _____

Other concerns: _____

ALLERGIES

List anything that you are allergic to (medications, food, bee stings, etc.) and how each affects you.

ALLERGY	REACTION
1._____	_____
2._____	_____
3._____	_____

MEDICATIONS

Please list all the medications you are taking. Include prescribed drugs and over-the-counter drugs, such as vitamins and inhalers.

DRUG NAME	STRENGTH	FREQUENCY TAKEN
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____
4._____	_____	_____
5._____	_____	_____
6._____	_____	_____
7._____	_____	_____
8._____	_____	_____
9._____	_____	_____
10._____	_____	_____

IMMUNIZATION HISTORY

Immunizations and most recent date:

- ☐ Flu Shot Date:_____
- ☐ Tetanus/Diphtheria/Pertussis (DPT) Date:_____
- ☐ Chickenpox Date:_____
- ☐ Measles/Mumps/Rubella (MMR) Date:_____
- ☐ Human Papillomavirus (HPV) Date:_____
- ☐ Shingles Date:_____
- ☐ Pneumonia Vaccine Date:_____
- ☐ Hepatitis A Date:_____
- ☐ Hepatitis B Date:_____
- ☐ Haemophillus Influenza Type B (Hib) Date:_____
- ☐ Meningitis Vaccine Date:_____

(WOMEN ONLY) OBSTETRIC AND GYNECOLOGICAL HISTORY

Age at First Menstrual Cycle _____

Date of Last Menstrual Cycle Date: _____

Age at First Child: _____

Current Birth Control Method: _____

Date of Last Pap Smear Date: _____ ☐ normal ☐ abnormal

Date of Last Mammogram Date: _____

If Post Menopausal, Age at Menopause _____

Post Menopausal Bleeding ☐ Yes ☐ No

PAST MEDICAL HISTORY

Please check all that apply:

- ☐ Abnormal Vaginal Bleeding
- ☐ Acid Reflux (GERD)
- ☐ Anemia
- ☐ Asthma
- ☐ Back Pain
- ☐ Bladder or Kidney Problems
- ☐ Cancer
- ☐ Congestive Heart Failure (CHF)
- ☐ COPD
- ☐ Difficulty Sleeping
- ☐ Dizziness
- ☐ Dementia/Alzheimers
- ☐ Depression
- ☐ Diabetes
- ☐ DVT/Blood Clot
- ☐ Epilepsy/Seizures
- ☐ Headaches
- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ Kidney Stones
- ☐ Parkinson's Disease
- ☐ Recurrent Urinary Tract Infection
- ☐ Thyroid Disorder
- ☐ TIA/Stroke
- ☐ Other: _____

PAST SURGICAL HISTORY

	SURGERY	REASON	YEAR	HOSPITAL
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____

FAMILY HEALTH HISTORY

RELATION	ALIVE?	AGE	SIGNIFICANT HEALTH PROBLEMS (Circle the conditions that apply)
Grandmother (maternal)	Y/N	_____	Alcohol abuse / Alzheimer's disease / Arthritis / Asthma / Autism / Cancer / COPD / Depression / Diabetes / Disorder of Thyroid Gland / Heart Disease / High Blood Pressure High Cholesterol / Obesity / Osteoporosis / Stroke
Grandfather (maternal)	Y/N	_____	Alcohol abuse / Alzheimer's disease / Arthritis / Asthma / Autism / Cancer / COPD / Depression / Diabetes / Disorder of Thyroid Gland / Heart Disease / High Blood Pressure High Cholesterol / Obesity / Osteoporosis / Stroke
Grandmother (paternal)	Y/N	_____	Alcohol abuse / Alzheimer's disease / Arthritis / Asthma / Autism / Cancer / COPD / Depression / Diabetes / Disorder of Thyroid Gland / Heart Disease / High Blood Pressure High Cholesterol / Obesity / Osteoporosis / Stroke
Grandfather (paternal)	Y/N	_____	Alcohol abuse / Alzheimer's disease / Arthritis / Asthma / Autism / Cancer / COPD / Depression / Diabetes / Disorder of Thyroid Gland / Heart Disease / High Blood Pressure High Cholesterol / Obesity / Osteoporosis / Stroke
Father	Y/N	_____	Alcohol abuse / Alzheimer's disease / Arthritis / Asthma / Autism / Cancer / COPD / Depression / Diabetes / Disorder of Thyroid Gland / Heart Disease / High Blood Pressure High Cholesterol / Obesity / Osteoporosis / Stroke
Mother	Y/N	_____	Alcohol abuse / Alzheimer's disease / Arthritis / Asthma / Autism / Cancer / COPD / Depression / Diabetes / Disorder of Thyroid Gland / Heart Disease / High Blood Pressure High Cholesterol / Obesity / Osteoporosis / Stroke
Brother/Sister	Y/N	_____	Alcohol abuse / Alzheimer's disease / Arthritis / Asthma / Autism / Cancer / COPD / Depression / Diabetes / Disorder of Thyroid Gland / Heart Disease / High Blood Pressure High Cholesterol / Obesity / Osteoporosis / Stroke
Brother/Sister	Y/N	_____	Alcohol abuse / Alzheimer's disease / Arthritis / Asthma / Autism / Cancer / COPD / Depression / Diabetes / Disorder of Thyroid Gland / Heart Disease / High Blood Pressure High Cholesterol / Obesity / Osteoporosis / Stroke
Other:_____	Y/N	_____	Alcohol abuse / Alzheimer's disease / Arthritis / Asthma / Autism / Cancer / COPD /

SOCIAL HISTORY

Marital Status

☐ Married ☐ Single ☐ Separated
☐ Divorced ☐ Widowed ☐ Domestic Partner

Exercise Level

☐ None (No exercise)
☐ Occasional exercise
☐ Moderate exercise
☐ High level exercise

Alcohol Consumption

Do you drink alcohol?
☐ Yes ☐ No

If so, how often?
☐ Occasionally
☐ Less than 3 times a week
☐ Greater than 3 times a week

How many drinks per week?
____

Illicit Drug Use

Do you take recreational drugs?
☐ Yes ☐ No

Tobacco Use

Do you use tobacco products?
☐ Yes ☐ No

If not currently, did you ever use tobacco?
☐ Yes ☐ No

If you have or are currently smoking, indicate the type of tobacco and frequency below:
☐ Cigarette - ____ pack(s)/day
☐ Cigar - ____ pack(s)/day
☐ Chewing Tobacco - ____ pack(s)/day
☐ Smokeless Tobacco - ____ pack(s)/day
☐ E-Cigarette/Vape - ____ pack(s)/day

For how long?
Number of years____
If no longer smoking, what year did you quit? _____

Please provide any additional information to your health care provider.

_____ _____
Parent, Guardian, or Caregiver Signature Date

_____ _____
Patient Signature Date

Live Oak Health Partners San Marcos Specialty Care
1340 Wonder World Dr Suite 4301
SAN MARCOS, TX 78666-7598
Phone: 5123536400, Fax: 5123533039

Form of Written Acknowledgment of Receipt
of SPECIALTY PHYSICIANS OF CENTRAL TEXAS INC's Notice of Patient Privacy Practices

By signing this Written Acknowledgment of Receipt of SPECIALTY PHYSICIANS OF CENTRAL TEXAS INC's Notice of Patient Privacy Practices("Acknowledgment"), I hereby expressly acknowledge my receipt of SPECIALTY PHYSICIANS OF CENTRAL TEXAS INC's Notice of Patient Privacy Practices.

_____
Patient, or Legal Representative, Signature

_____
Printed Patient, or Legal Representative, Name (or label)

_____
Date

Acknowledgment **NOT** obtained because:

_____ Patient, or legal representative, declined Notice of Patient Privacy Practices;

_____ Patient treated in an emergency room and discharged before obtaining Acknowledgment;

_____ Other (briefly describe)_____

_____
Employee Signature

_____
Employee Printed Name

_____
Date

1340 Wonder World Dr Suite 4301
SAN MARCOS, TX 78666-7598

General Consent and Service Terms

General Consent for Treatment

I agree to allow SPECIALTY PHYSICIANS OF CENTRAL TEXAS INC and its Physicians to provide all health care services to me that are routine or otherwise deemed necessary. I understand I have the right to refuse consent to any proposed procedure or treatment at any time prior to receiving it. I understand that any treatment involving material risks will be explained to me and that I will have the opportunity to ask questions about the associated risks, alternatives and prognosis before allowing the treatment to be performed. I agree that no guarantees have been given to me as to the outcome of any treatment. I agree my picture can be taken to identify me.

General Sharing of Health Information

I agree and have initialed below for the Medical Group, its affiliates, and Physicians using and sharing all of my health information, including but not limited to Highly Confidential Information (Mental health, HIV/AIDS, genetic testing, venereal disease, and rape/sexual assault information), for payment, my continued treatment, and healthcare operations. This includes sharing my information with the following:

All physicians and other medical service providers associated with my treatment, other entities owned or managed by Adventist Health System, as well as other physicians who are participating in integrated physician plan networks or Health Information Exchanges.

Business partners of the Medical Group, its affiliates, and Physicians, who provide administrative, operational, financial, legal and technical support services.

All insurance Payer(s) and healthcare plans responsible for paying or determining if I am eligible for payment for my treatment.

Initial here:

Substance, Drug, and Alcohol Abuse Authorization

I authorize and have initialed below for the Medical Group, its affiliates, Physicians, and Adventist Health System to release; should any exist, all of my substance abuse and drug and alcohol abuse health information to the Medical Groupâ€™s affiliates for my treatment, payment for my treatment, and the health care operations of the Medical Group, its affiliates, and Physicians. I understand this authorization may be cancelled at any time, unless the Medical Group, its affiliates, and Physicians have already acted and relied on it. If not previously revoked, I understand this authorization is effective until I am deceased.

Initial here:

Insurance Assignment and Payment

I permanently assign my third party payer benefits payable directly to the Medical Group. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any services rendered.

I understand and agree that payment of my out-of-pocket portion for all elective services must be paid 10 days prior to receiving the service or the service will be cancelled and then rescheduled when such payment is received. If I do not pay for all of my services and an attorney or collection agency asks me to pay, I agree to pay the reasonable attorneys' fees and/or collection expenses in addition to paying for the cost of all my services.

I authorize the Medical Group to file an appeal on my behalf for any denial of payment and/or adverse benefit determination related to services and care provided. If my health insurance or third party payer will not direct payment to the Medical Group, I agree to forward to the Medical Group all health insurance payments which I receive for the services rendered by the Medical Group.

Unless otherwise designated by the payer, I understand the Medical Group posts all payments received to the oldest balances first, with the exception of copays, drugs, and supplies. I give permission to apply any credit balances to offset amounts due to the Medical Group or other Medical Groups owned by Adventist Health System where I have received services for current accounts or accounts I have not paid yet.

I authorize the use of my signature below on all insurance submissions. I may at any time in the future cancel this authorization in writing.

Medicare Assignment of Benefits

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare Claim. I permit a copy of this authorization to be used in place of the original. I request that payment of the authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

Self-Pay Request

If I do not want my insurance company(ies) to receive health care information about this treatment I understand I will need to inform the staff and complete the Request to Restrict Use and Disclosure of Protected Health Information form.

Communication

Messages and Mail:
I understand you may communicate with me through US Mail, electronic mail, telephone or voice mail messages, to remind me about my appointments, treatment follow-up or to tell me about new services that are available. I understand that I must tell you if I do not want you to communicate with me like this.

Sharing PHI with family and friends:
I understand you will share my PHI with the family members, friends, or other individuals who are present with me unless I tell you otherwise.

Wireless Calls and Texting:
I agree and have initialed below for the Medical Group and its affiliates to use an automated telephone dialing system, and texting, to contact the cellular telephone number(s) that I provided for appointment, treatment, and payment purposes.

Initial here:

Signatures

BY SIGNING BELOW, I AM AGREEING TO THE PERMISSIONS, AGREEMENTS, AND AUTHORIZATIONS DESCRIBED IN THIS AGREEMENT. I HAVE READ THIS AGREEMENT AND HAVE BEEN ABLE TO ASK QUESTIONS. I UNDERSTAND THIS AGREEMENT IS VALID FOR ONE YEAR FROM THE DATE I SIGN IT.

Printed Name of Patient or Legal Representative: Date:

Patient or Legal Representative Signature: Date:

Relationship of Person signing if not Patient:

CONFIDENTIAL COMMUNICATION REQUEST

This form indicates the means of communication that I prefer to remind me of my appointment, communicate test results and follow-up visits.

I consent to the release of any medical information or test results to the following persons:

- o My Spouse: _____
- o My child/children: _____
- o My parents: _____
- o Other: _____

I wish to be contacted in the following manner (check all that apply)

- o Home Telephone: _____
  - ☐ Permission to leave a message with detailed information
  - ☐ Leave Name/Doctor with call back number **ONLY**
- o Cell Phone: _____
  - ☐ Permission to leave a message with detailed information
  - ☐ Leave Name/Doctor with call back number **ONLY**
- o Work Telephone: _____
  - ☐ Permission to leave a message with detailed information
  - ☐ Leave Name/Doctor with call back number **ONLY**
- o Patient Portal
  - ☐ Email Address: _____
- o When unable to contact me by phone, a written communication may be sent to:
  - ☐ Home address on file
  - ☐ Alternate Address:

    _____
    _____
    _____

Patient Signature: _____ Date: _____

Print Name: _____ Date of Birth: _____

Live Oak Health Partners
1340 Wonder World Drive, Bldg 4, Suite 4301
San Marcos, TX 78666
(512)353-6400 Fax# (512) 353-3039

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, _____ hereby authorize

Physician or Facility: LIVE OAK HEALTH PARTNERS
1340 Wonder World Drive , Bldg 4, Ste 4301
San Marcos, Texas 78666
(512) 353-6400 Fax# (512) 353-3039

To release the complete history records in your possession.

SEND RECORDS TO:	SEND RECORDS FROM:
_____	_____
_____	_____
_____	_____
_____	_____

I understand that this consent can be revoked at any time except to the extent that disclosure made in good faith has already occurred in reliance on this consent. If revocation is not received, authorization will be considered valid for a period of time not to exceed 90 days.

The facility, its employees and officers and attending physician are released from legal responsibility or liability for the release of the requested information to the extent indicated and authorized herein.

I understand that the information released could contain reference to or results of HIV Antibody (AIDS) testing, and/or alcohol or substance abuse.

Date: _____ Signed _____

Witness _____ Address _____

_____

Vital Information: Date of Birth: _____ SSN: _____

Maiden Name or Any Other Name Records May Be Under:

_____

_____

Appropriate Dates of Information Needed: _____

_____

Information Needed: _____

_____

Previous Address: _____

_____

Christopher Jimenez, MD; Joint Pain Orthopedics PLLC Photo and Promotional Release Form

I hereby consent to be interviewed, recorded, photographed, videotaped, or filmed by Dr. Christopher Jimenez, MD or an affiliate of Joint Pain Orthopedics PLLC for purposes of publication, display, educational talks, or broadcast (print, web, digital display, and all other forms of media).

I agree that such interviews, recordings, articles, quotes, photographs, films, audio, or video and/or any reproductions of same in any form, are the property of Dr. Christopher Jimenez, MD and the Joint Pain Orthopedics PLLC, and I relinquish any present or future claim for reimbursement for said photographic or film reproduction of my likeness or for said testimonials by me.

I hereby release Dr. Christopher Jimenez, MD, Joint Pain Orthopedics PLLC, his affiliates, employees, representatives, and agents from any and all claims, demands, costs, and liability that may arise from the use of these interviews, recordings, photographs, videotapes, or films, and/or any reproductions of same in any form, as described above, arising out of being interviewed, recorded, photographed, videotaped, or filmed.

I acknowledge that I have read this consent form in its entirety, or it has been read (or translated) to me, and I have had the opportunity to ask questions about it and understand it.

Date: _____

Name (print): _____

Signature: _____