Patient Name: _____ DOB: _____

Marital Status: S M W D Sex: Male/Female SS#_____

Address: _____ City:_____ State:_____ Zip:_____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Email Address: _____

Ethnicity: _____ Race: _____ Language:_____

Employer Name & Address: _____

Preferred Pharmacy

Pharmacy Name: _____ Address: _____

Phone: _____

Emergency Contact

Name:_____Relationship:_____Phone: _____

Name:_____Relationship:_____Phone:

How Did You Hear About Us? _____

Responsible Party-Minor ONLY
(only complete if under the age of 18)

Who is responsible for payment for this patient?_____DOB: _____

Relationship to Patient:_____Phone: _____

Insurance

Primary Insurance:_____Phone # _____

ID: _____ Group #: _____

Insured Name: _____ DOB: _____ Relation: _____

Secondary Insurance:_____ ID:_____ Group: _____

Patient Signature: _____Relation to Patient: _____ Date: _____

Patient History Form

FAMILY FOCUSED CARE
HEALTH FUSION OF TEXAS

Patient Name:			
Date of Birth:			
Social History:	**Married, Single or Divorced:**	**Sexually Active:**	**Yes or no**
Current Smoker or Tabacco Use	**Yes No Never**	**Type:**	**# of yrs.**
Current Alcohol Use	**Yes No Never**	**Freq:**	**Amount:**

Personal & Family History:					**Maternal**		**Paternal**	
	Self	**Mom**	**Dad**	**Bro/Sis**	**GM**	**GF**	**GM**	**GF**
If deceased, list approx. age of								
Neuro:								
Migraines								
Stroke								
Mental Health:								
Anxiety/Depression								
Drug/Alcohol Abuse								
ENT- Allergies								
Endocrine:								
Diabetes Type I or II								
Thyroid Disorder								
Cardiovascular								
High Blood Pressure								
High Cholesterol								
Resp- Asthma/COPD								
GI- GERD/REFLUX/ULCER								
Gynecology								
Endometriosis/PCOS								
Urology/Renal								
Kidney Stones/disease								
Cancers:								
Breast Cancer								
Colon Cancer								
Prostate Cancer								
Skin Cancer (type)								
Other-								
Viral History:								
Hepatitis A, B or C								
Ebstein Barr/ Mono								
HSV I/HSV II								
Other Viral/STD History								
Other Medical Conditions:								

Ob/GYN History:	Last Menstrual Cycle:	Type Birth Control:
	Last Pap:	Last Mammo:
# of Pregnancies:	# of Vaginal Deliveries:	# of C-Sections:

Surgical History (list year & type)

I certify the above information is correct to the best of my knowledge. I will not hold my provider or any staff member. responsible for any error or omissions that I may have made during the completion of this form.

Signature: **Date:**

Drug Allergies & Reaction	

Current Medication List		
Drug Name	**Dose**	**Freq.**

Current Supplement List		
Supplement	**Dose**	**Freq.**

Preferred Pharmacy