CONTACT INFORMATION

Please fill in your name and other demographic information that may need to be changed or updated in our files.

Metroplex Wellness Inc
Dr. Thwaites
214-205-2661
www.metroplexwellness.com

Today's Date (MM/DD/YYYY)

Patient Number (office use only)

Age

Gender
◯ Male ◯ Female

Race
◯ American Indian ◯ Alaskan Native ◯ Asian ◯ Black or African American
◯ Native Hawaiian ◯ Other Pacific Islander ◯ Other ◯ White
◯ Decline to answer

Ethnicity
◯ Hispanic or Latino
◯ Not Hispanic or Latino
◯ Decline to specify

Birth Date (MM/DD/YYYY)

Your Last Name

Your Social Security Number

Your First Name

Your Middle Name (or Initial)

Smoking Status (age 13 and over)
◯ Never A Smoker ◯ Former Smoker
◯ Current Every Day Smoker ◯ Current Some Day Smoker
◯ Heavy Smoker ◯ Light Smoker

Address

Marital Status ◯ Married
◯ Single ◯ Divorced
◯ Widowed ◯ Separated

City | **State/Province** | **ZIP/Postal Code**

Preferred Language

Home Phone

Cell Phone

Spouse's Name

Email Address

Child's Name and Age

Emergency Contact

Emergency Contact's Phone

Child's Name and Age

Your Occupation

Child's Name and Age

Your Employer

Work Phone

Address

May we contact you at work?
◯ Yes ◯ No

City | **State/Province** | **ZIP/Postal Code**

Preferred method of contact?
◯ Home Phone ◯ Cell Phone
◯ Work Phone ◯ Email

Primary Care Provider's Name

Insurance Carrier

Policy Number

Insured's Last Name

Birth Date (MM/DD/YYYY)

Who carries this policy?
◯ Self ◯ Spouse ◯ Parent

Insured's First Name

Insured's Middle Name (or Initial)

Insured's Employer

Address

City | **State/Province** | **ZIP/Postal Code** | **Employer's Phone**

I certify that any changes to my personal information have been updated above for your records.

Signature

CONTACT INFORMATION

PATIENT HISTORY

Metroplex Wellness Inc
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214-205-2661
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Review of Systems: If you have any recent trouble with following issues, check the problem(s) listed. If you do not have any of problem selectons, check the "No problem" box.

Patient name _____

Patient Number (office use only) _____

GENERAL

Onset (When did you first notice your current symptoms?) _____

- ◯ Unusual weight changes
- ◯ Fever
- ◯ Fatique
- ◯ Weakness
- ◯ Pain
- ◯ No Problem

Skin

Onset (When did you first notice your current symptoms?) _____

- ◯ Rashes
- ◯ Dryness
- ◯ Changes in skin, hair or nails
- ◯ No Problem

Eyes

Onset (When did you first notice your current symptoms?) _____

- ◯ Pain
- ◯ Excessive tearing
- ◯ Dryness
- ◯ Redness
- ◯ Blurring vision
- ◯ Vision halos
- ◯ Vision flashes
- ◯ Eyestrain
- ◯ No Problem

Ears

Onset (When did you first notice your current symptoms?) _____

- ◯ Drainage
- ◯ Earache
- ◯ Constant ringing
- ◯ Hearing loss
- ◯ No Problem

Nose

Onset (When did you first notice your current symptoms?) _____

- ◯ Nosebleeds
- ◯ Post nasal drip
- ◯ Discharge
- ◯ Sinus pain
- ◯ No Problem

Mouth

Onset (When did you first notice your current symptoms?) _____

- ◯ Gum soreness
- ◯ Tongue pain
- ◯ Teeth condition
- ◯ No problem

Throat

Onset (When did you first notice your current symptoms?) _____

- ◯ Hoarseness
- ◯ Swelling
- ◯ Trouble swallowing
- ◯ No Problem

Lungs

Onset (When did you first notice your current symptoms?) _____

- ◯ Shortness of breath
- ◯ Cough
- ◯ Coughing blood
- ◯ Pneumonia
- ◯ Wheezing
- ◯ Phlegm/Sputum
- ◯ Pleurisy
- ◯ Asthma
- ◯ Snoring
- ◯ Apnea
- ◯ No Problem

Heart & Circulation

Onset (When did you first notice your current symptoms?) _____

- ◯ Chest pain, tightness or pressure
- ◯ Irregular heart beat
- ◯ Fast or slow heart beat
- ◯ Ankle swelling
- ◯ Low blood pressure
- ◯ High blood pressure
- ◯ No Problem

PATIENT HISTORY

Doctor's Initials _____

PATIENT HISTORY

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Review of Systems: If you have any recent trouble with following issues, check the problem(s) listed. If you do not have any of problem selectons, check the "No problem" box.

Patient name _____

Patient Number (office use only) _____

Urinary

Onset (When did you first notice your current symptoms?) _____

- ◯ Frequency of painful urinating
- ◯ Pus in urine
- ◯ Losing control of urine/wetting self
- ◯ Urinating at night
- ◯ Blood in urine
- ◯ No Problem

Stomach, Intestines and Colon

Onset (When did you first notice your current symptoms?) _____

- ◯ Nausea
- ◯ Vomiting
- ◯ Vomiting blood
- ◯ Change in bowel habits
- ◯ Constipation
- ◯ Diarrhea
- ◯ Food intolerance
- ◯ Rectal bleeding
- ◯ Indigestion
- ◯ Flatus/Passing gas
- ◯ No Problem

Muscles, Joints & Bones

Onset (When did you first notice your current symptoms?) _____

- ◯ Joint stiffness or pain
- ◯ Backache
- ◯ Limitation of joint muscle movement
- ◯ Joint swelling or redness
- ◯ Muscle pains or cramps
- ◯ Bone pain
- ◯ No problem

Nervous System

Onset (When did you first notice your current symptoms?) _____

- ◯ Fainting
- ◯ Seizures/Epilepsy
- ◯ Tremors
- ◯ Memory loss
- ◯ Blackouts
- ◯ Paralysis
- ◯ Tingling of part of body
- ◯ Headaches
- ◯ No problem

Hormones

Onset (When did you first notice your current symptoms?) _____

- ◯ Heat or clod intolerance
- ◯ Excessive thirst, hunger or urination
- ◯ No problem

Blood/Allergies

Onset (When did you first notice your current symptoms?) _____

- ◯ Anemia
- ◯ Bleeding gums
- ◯ Easy bruising or bleeding
- ◯ Hives or welts
- ◯ No problem

Psychological

Onset (When did you first notice your current symptoms?) _____

- ◯ Depression
- ◯ Loss of interest in activities that are normally enjoyed
- ◯ Difficulty sleeping
- ◯ Difficulty concetrating
- ◯ Nervouseness
- ◯ Alcohol and drug abuse
- ◯ No problem

Genitals

Onset (When did you first notice your current symptoms?)

MEN ONLY _____

- ◯ Sores
- ◯ Groin swelling
- ◯ Penile discharge
- ◯ Hernias
- ◯ Testicular pain or masses
- ◯ Breast lump
- ◯ Erection difficulties
- ◯ No Problem

WOMEN ONLY _____

- ◯ Irregular periods
- ◯ Very painful periods
- ◯ Bleeding between periods
- ◯ Sores
- ◯ Vaginal discharge
- ◯ Breast lump
- ◯ Painful intercourse
- ◯ No Problem

PATIENT HISTORY

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CURRENT MEDICATIONS List of all medications that you take routinely or that have been prescribed for you by a doctor
(include vitamins, over-the-counter medications, eye drops, herbal medications, etc.)

Medication	Dose	How often	Reason

Allergies

◯ None ◯ Antibiotics ◯ Foods ◯ Inhalants ◯ Insects ◯ Latex ◯ Meds ◯ Pollens ◯ Skin ◯ Transfusions ◯ X-Ray Contrast

Specify: _____

PAST MEDICAL HISTORY Please check any of the following conditions/problems/deseases that you either now have or have been diagnosed with in the past

◯ Abuse (Phisical/Mental/Sexual/Verbal, etc.)	◯ Blood transfusion	◯ Glaucoma / Cataract	◯ Osteoporosis
◯ Abnormal PAP	◯ Blood clots	◯ Gout	◯ Serious accident / Injury
◯ Alcoholism / Drugs	◯ Cancer /Tumor	◯ Headaches / Migraine	◯ Sexual deseases / VD
◯ Anemia	◯ Cholesterol (high)	◯ Heart desease	◯ Stroke
◯ Anxiety / Nerves	◯ Chronic pain	◯ Hepatitis (Any)	◯ Thyroid desease
◯ Arthritis	◯ Depression	◯ High blood pressure	◯ Tuberculosis
◯ Asthma	◯ Diabetes / Sugar	◯ Intestinal desease	◯ Ulcers /Stomach disease
◯ Allergies	◯ Epilepsy / Seizures	◯ Kidney or bladder probs	
◯ Bleeding desease	◯ Genetic deseases	◯ Lung desease	

Other: _____

Are you intended in learning more about your health condition? **Yes** ◯ **No** ◯

Patient name _____

Patient Number
(office use only) _____

PATIENT HISTORY

Doctor's Initials _____

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Patient name

Patient Number
(office use only)

PAST SURGICAL HISTORY

List the year you had any of the following:

Appendectomy _____	**Gallbladder** _____	**Hernia** _____
Blood transfusion _____	**Heart / Cath** _____	**Tonsillectomy** _____
Hysterectomy _____	**Tubal / Vasectomy** _____	

Other: _____

HOSPITALISATION / MAJOR TRAUMA

Date (Start with most recent)	**Reason**	List any **Major tests or procedures** done

FAMILY HISTORY

Blood relatives	Age if living	Age at death	Major ilnesses & / or cause of death Choose from PAST MEDICAL HISTORY section on previous page)
Mother			
Grandmother			
Grandfather			
Father			
Grandmother			
Grandfather			
Brothers #: _____			
Sisters #: _____			
Childen #: _____			

List any other deseases that your blood relatives have

_____

_____

PATIENT HISTORY

Doctor's Initials

PATIENT HISTORY

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HABITS Do you use (or have used) any of the following:

Tobacco:

◯ Never ◯ Now Quit (year) _____

Type used

◯ Cigarettes
◯ Cigars
◯ Pipe
◯ Smokeless

Amount per day: _____

How many years: _____

Alcohol:

◯ Never ◯ Social / Rare
◯ Quit (year) _____

Type used	**Amount used per week:**
◯ Beer	_____ **12 oz beers**
◯ Wine	_____ **6 oz wine**
◯ Liquour	_____ **2 oz shots**

Drug use:

◯ Never ◯ Now
◯ Quit (year) _____

Type used

◯ Pot ◯ IV
◯ Cocaine ◯ Pain pills
◯ Other _____

Caffeine:

Per day _____ Coffee (cups) _____ Tea (glasses) _____ Soda (12 oz cans) _____

Exercise:

◯ None per week ◯ # of time / week _____ Type: _____

Patient name _____

Patient Number (office use only) _____

NUTRITIONAL ASSESSEMENT

Do you follow a special diet or have any dietary restrictions?

◯ No ◯ Yes Specify _____

HEALTHCARE MAINTENANCE

Immunization:

Hep A: Year _____ Hep B: Year _____ Zostavax: Year _____ Pneumonia:: Year _____ Tetanus: Year _____

Screening exams:

Cholesterol: Year _____ value: _____ Mammogram: Year_____ PAP: Year_____ Colonoscopy: Year _____

Colonoscopy: Year _____ PSA: Year _____ Dexa Scan: Year _____

COPING / STRESS TOLERANCE ASSESSMENT

Describe how you manage stress: ◯ Exercize ◯ Gardening ◯ Hobbies ◯ Read ◯ Sports ◯ TV
Other: _____

Who lives with you? ◯ Alone ◯ Spouse ◯ Childen ◯ Parent(s) Other _____

Current stressors: ◯ Family ◯ Friends ◯ Job ◯ Marriage ◯ Money Other _____

In the past year have you had a major loss or change in you life? ◯ No ◯ Yes Specify _____

VALUES / BELIEFS ASSESSMENT

Check if you have any of the following documents: ◯ Donor card ◯ Living will ◯ Durable power of attorney for Health care

Do you have religious or cultural practices we should be aware of? ◯ No ◯ Yes Specify _____

Health care information can be shared with the following people: _____

_____

PATIENT HISTORY

Doctor's Initials _____