FIRST NAME: ______________ **LAST NAME:** __________________ **DOB:** _____

******PHARMACY NAME (location**

ALLERGIES

MEDICATIONS OR FOODS	REACTION/COMMENTS

MEDICATIONS – PRESCRIPTION AND OVER THE COUNTER

NAME	DOSE & DIRECTIONS	REASON

IMMUNIZATIONS

Flu Vaccine	Date:
Pneumococcal Vaccine	Date:
Tetanus, Diphtheria – with or without Whooping Cough (circle one)	Date:
Shingles	Date:
Colonoscopy or Cancer Screening	Date:

CHECK ALL THAT APPLY TO PAST AND PRESENT MEDICAL CONDITIONS

- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Blood Clots
- ☐ Cancer
- ☐ Coronary Artery/Heart Disease
- ☐ Congestive Heart Failure
- ☐ Dementia
- ☐ Depression/Anxiety
- ☐ Diabetes
- ☐ Emphysema
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Osteoporosis
- ☐ Peripheral Artery Disease
- ☐ Positive TB Test
- ☐ Prostate Problem
- ☐ Seizure Disorder
- ☐ Sexually Transmitted Disease
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Ulcers of the Stomach

FAMILY HISTORY

Check any of the diseases that run in your family and please note who had it:

	None	Mother	Father	Sister	Brother	Grandmother (mother's side)	Grandfather (mother's side)	Grandmother (father's side)	Grandfather (father's side)	Children	Other (Please Explain)
Alcoholism or drug use											
Cancer (list type)											
Diabetes											
Heart Disease											
High Blood Pressure											
High Cholesterol											
Osteoporosis											
Mental Illness											
Stroke											
Thyroid Disease											
Other											

HEALTH HABITS

Do you smoke or use any tobacco products? .... ___Yes ___ No

Number of cigarettes each day? ___________ for how many years? ___________

Other forms of tobacco used? ___________

Occupation: ___________________________

Education (level) ___________________________

Marital Status: ___________________________

Exercise: yes__________ No __________

Regular Diet: ___________________________

Do you drink alcohol? .... ___Yes ___ No

How much? ___________ How often? ___________

Have used illicit drugs? .... ___Yes ___ No

If yes, are you still using them? ....___Yes ___ No

SURGICAL HISTORY (Check all that apply)

- ☐ Appendectomy
- ☐ Cardiac Angioplasty, Stent or Bypass
- ☐ Cardiac Catheterization
- ☐ Cesarean Section
- ☐ Gall Bladder – Laparoscopic
- _ Orthopedic
- ☐ Hysterectomy – Partial
- ☐ Hernia Repair
- ☐ Prostate Surgery

OTHER
SURGERIES: ____

____

____

SEXUAL HISTORY

Are you sexually active? .... ___Yes ___No

With: ___ Men ___ Women ___ Both

Do you feel you are at risk for HIV/AIDS? .... ___Yes ___ No

Do you have children? .... ___Yes ___ No

Do you use any form of birth control? .... ___Yes
___ No

If yes, what brand/type? ____________________

GYNECOLOGICAL HISTORY

Duration of flow (days) ____________________

LMP ____________________

Menses monthly YES _______ NO _______

Flow heavy ____________ Light ____________

Number of children__________ AGES __________

Current birth control ____________________

Date last PAP ____________ Abnormal: (yes)______ (no)______

Bone density__________

Last Mammogram ____________ Normal (yes)_____ (no) _____

PERSONAL HISTORY

Are you currently married or living with a significant other? .... ___Yes ___ No

Who lives with you at home? ____________________

Are you employed? .... ___ Yes ___ No

If yes, what kind of work do you do? ______________________________

If no, is this by choice? _____ Disability? _____ Other Reasons? ____________

Burleson Old Town Medical Center
312 E. Renfro ST, suite#101
Burleson, TX 76028

I________________________________ Authorize Burleson Old Town Medical to release all and any information to:

Name: ____________________________ Relationship: ______________ Phone# ___________

Name: ____________________________ Relationship: ______________ Phone# ___________

Name: ____________________________ Relationship: ______________ Phone# ___________

Name: ____________________________ Relationship: ______________ Phone# ___________

Name: ____________________________ Relationship: ______________ Phone# ___________

Name: ____________________________ Relationship: ______________ Phone# ___________

Name: ____________________________ Relationship: ______________ Phone# ___________

Patient's signature ___________________________________ Date: ___________

(If patient is under age 17)Parent's signature: _______________________ Date: _________

Old Town Medical

Johnson County Concierge

312 E Renfro Suite 202

Burleson, TX 76028

Patient agreement for controlled medication

I ____________________________, understand and voluntary agree that (initial each statement)

___ I will keep and be on time to all scheduled appointments.

___ I will keep medication safe, secure and out of reach of children.

___ If, medication is lost or stolen, I understand it will not be replaced.

___ I will take medication ONLY as directed.

___ Medication will not be filled early.

___ I will not use multiple providers for controlled medication, unless discussed with provider.

___ I will only use one pharmacy, which is ____________________________.

___ I will make an appointment prior to needing refills.

___ I will not share, sell or trade medication with anyone.

___ I will sign release for OTM & Johnson County Concierge to retrieve records from other providers.

___ I will be asked to do random Urine Drug Screens.

****___ I WILL NOT use illegal drugs such as marijuana, cocaine, heroin or amphetamines. If I test positive for such drugs, I will not receive controlled medication. If clear on next UDS, the decision between myself and the provider will be made to continue such medication. If at any time there after UDS is positive <u>NO</u> more controlled medication will be written and I may be discharged for the practice due to non -compliance .******

___ I will keep office updated with my phone number and address.

___ I will treat staff at with respect at all times.

Patient signature : ______________________________ Date _________

Patient printed name ____