

HISTORY AND PHYSICAL EXAMINATION

DATE _____

DATE OF BIRTH _____ AGE _____

NAME _____

PREFERRED NAME _____

PRESENT ILLNESS (REASON FOR THE APPOINTMENT TODAY) _____

PAST MEDICAL HISTORY (LIST ALL HOSPITALIZATIONS AND OPERATIONS)

YEAR

OPERATIONS AND ILLNESSES

FUNCTIONAL INQUIRY (INDICATE 'YES' OR 'NO' TO **ALL** OF THE FOLLOWING QUESTIONS)

GASTRIC / INTESTINAL DISEASE	Y / N	KIDNEY DISEASE	Y / N	HEART DISEASE	Y / N
HIGH BLOOD PRESSURE	Y / N	DIABETES	Y / N	TUBERCULOSIS	Y / N
LUNG DISEASE	Y / N	RHEUMATIC FEVER	Y / N		

DO YOU HAVE ANY OTHER ILLNESSES NOT LISTED ABOVE: Y / N (IF YES, PLEASE LIST ILLNESSES)

ARE YOU ALLERGIC TO ANY MEDICATIONS? Y / N (IF YES, PLEASE LIST MEDICATIONS)

ARE YOU CURRENTLY TAKING ANY MEDICATIONS? Y / N (IF YES, PLEASE LIST MEDICATIONS INCLUDING HERBAL)

PERSONAL HISTORY:

MARITAL STATUS: S M W D

NUMBER OF CHILDREN: _____

DO YOU SMOKE CIGARETTES? Y / N

DO YOU DRINK ALCOHOL? _____

HOW MANY PER DAY? _____

FREQUENCY & AMOUNT? _____

MAY WE LEAVE MESSAGES ON YOUR PHONE REGARDING YOUR MEDICAL INFORMATION? Y / N

FAMILY HISTORY:

	AGE	CONDITION OF HEALTH OR CAUSE OF DEATH
MOTHER		
FATHER		
BROTHERS		
SISTERS		

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This office may use and disclose medical and financial information related to your care that may be necessary now or in the future to facilitate payment by third parties for services rendered by us, or to assist with, aid in, or facilitate the collection of data for purposes of utilization review, quality assurance, or medical outcomes evaluation purposes. Such information may be released to insurance companies, HMO's and PPO's, managed care organizations, IPA's, Medicare/Medicaid, or other governmental or third party payors, or any organizations contracting with any of the above entities to perform such functions. Medical records may be delivered to a primary care physician or any other physician that is directly or indirectly responsible for your medical care or the payment thereof.

This office will not use or disclose any of your medical and financial information for any purpose not stated above without your specific authorization. You may revoke your authorization at any time.

You may request restrictions on certain uses and disclosures. This office is not required to agree to a requested restriction. You have the right to receive confidential communications of your protected health information. You have the right to inspect a copy and amend your protected health information. You may also request an accounting of disclosures of your protected health information from this office.

We are legally obligated to maintain the privacy of your protected health information, to provide you with this Notice of Privacy Practices, and to abide by its terms. We reserve the right to change our privacy practices and apply revised privacy practices to protected health information.

I will allow messages to be left on my answering machine or voice mail: Y / N

Persons authorized to discuss Medical Information:

Name: _____ Relationship _____ Phone _____

Name: _____ Relationship _____ Phone _____

You may register a complaint with this office if you suspect that your privacy rights have been violated. We will investigate the complaint and inform you of the findings. No retaliation will be made against you by this office because you registered a complaint. You may also file a complaint with the Secretary of the Department of Health and Human Services.

You may speak with the Office Manager or Privacy Officer to obtain additional information regarding any questions you may have concerning this Notice or to receive a printed copy of the Notice. This Notice of Privacy Practices is effective April 14, 2003.

Patient Name (Please Print) _____

Patient Signature _____ Date _____
(Or Legal Guardian)

PATIENT NAME: _____ DATE: _____

PATIENT HISTORY
 HAVE YOU EXPERIENCED ANY OF THE FOLLOWING RECENTLY?

CONSTITUTIONAL

Weight Gain	Y	N
Weight Loss	Y	N
Fatigue	Y	N
Weakness	Y	N
Fever	Y	N
Chills	Y	N
Night Sweats	Y	N

EYES

Unexplained Vision Problems	Y	N
Blurred Vision	Y	N
Double Vision	Y	N
Pain	Y	N

EARS/NOSE/MOUTH/THROAT

Ear Pain	Y	N
Ear Discharge	Y	N
Vertigo	Y	N
Nasal Discharge	Y	N
Nasal Congestion	Y	N
Nose Bleeds	Y	N
Bleeding Gums	Y	N
Mouth Lesions	Y	N
Neck Mass	Y	N
Neck Pain	Y	N

CARDIOVASCULAR

Chest Pain	Y	N
Palpitations	Y	N
Dyspnea (shortness of breath)	Y	N
Shortness of breath when lying down	Y	N
Edema	Y	N

RESPIRATORY

Difficulty breathing	Y	N
Wheezing	Y	N
Cough	Y	N
Bloody Cough	Y	N

GASTROINTESTINAL

Abdominal Pain	Y	N
Nausea	Y	N
Vomiting	Y	N
Diarrhea	Y	N
Constipation	Y	N
Heartburn	Y	N
Difficulty Swallowing	Y	N
No Appetite	Y	N
Blood in Mouth	Y	N
Blood in Rectum	Y	N

GU

Painful Urination	Y	N
Blood in Urine	Y	N
Urinary Incontinence	Y	N

MUSCULAR/SKELETAL

Back Pain	Y	N
Bone Pain Where _____	Y	N
Joint Pain Where _____	Y	N

SKIN

Rash	Y	N
Skin Lesions	Y	N
Nail Changes	Y	N

NEUROLOGICAL

Headache	Y	N
Fainting	Y	N
Paralysis	Y	N
Weakness	Y	N
Numbness	Y	N
Pain	Y	N
Confusion	Y	N

PSYCHOLOGICAL

Severe Anxiety	Y	N
Severe Depression	Y	N
Impaired Memory	Y	N
Sleep Difficulty	Y	N

HEMATOLOGY

Easy Bleeding	Y	N
Easy Bruising	Y	N

James J. Hudgins, MD
4001 W. 15th Street, Suite 180
Plano, Texas 75093-5836

WORKERS COMPENSATION PATIENT INFORMATION FORM

NAME: _____ **SS#** _____ **DrLic#** _____
 Last First MI

Age: _____ **DOB:** _____ **Sex:** Male () Female () **Marital Status:** M S W D

Address: _____ **Employer:** _____

City: _____ **State:** _____ **Address:** _____

Zip: _____ **Telephone:** _____ **City:** _____ **State:** _____

Zip: _____ **Telephone:** _____

Spouse: _____ **Emergency Contact other than spouse:** _____

Phone: _____ **SS#** _____ **Phone:** _____ **WK:** _____

Insurance Company: _____ **Claim#** _____

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

Contact: _____ **Phone:** _____ **Ext:** _____

Date of Injury: _____ **Injury to:** _____

Describe how the injury occurred: _____

Have you notified your employer? () Yes () No **Have you completed an injury report?** () Yes () No

Please list all physicians you have seen for this injury: _____

Who is your treating physician? _____ **Who referred you?** _____

ALLERGIES: _____

Present medical complaints relating to your injury are: _____

PATIENT AUTHORIZATION

I hereby authorize James J. Hudgins, MD to release my medical or other information necessary to process this claim in accordance with the TWCC guidelines. I further acknowledge that should the insurance company and the Texas Workers' Compensation Commission controvert this claim that I may become liable for medical expenses incurred.

Patient Signature: _____ **Date:** _____