HEALING COMPANION MEDICAL CLINIC
Dr. Nhu Quynh Tran, Internal Medicine

ATTENTION: THIS IS CONFIDENTIAL RECORD OF YOUR MEDICAL HISTORY. IT WILL BE KEPT IN YOUR CHART AND CAN ONLY BE RELEASED WITH YOUR PERMISSION

Date: _____ Gender: M F
Patient's Name: _____ Date of birth: _____ Age: _____
Address: _____ Marital Status: S M W D
_____ Occupation: _____
Home Phone: _____ Work Phone: _____

Who was your last physician? _____ Date last seen: _____

Family History: Please indicate which blood relative has any of the following illness (including yourself):

High blood pressure: _____ High Cholesterol: _____
Heart Disease or heart attack: _____ Diabetes: _____
Stroke: _____ Cancer: _____
Tuberculosis: _____ Arthritis: _____
Mental Illness: _____ Kidney Disease: _____
Glaucoma: _____ Other(s): _____

Hospital Admissions and Surgeries: **Dates:**
1) _____
2) _____
3) _____
4) _____
5) _____
6) _____
7) _____

Names of Current Medication:	**Strength**	**#taken per day**	**For what illness do you take it?**
1.			
2.			
3.			
4.			
5.			
6.			
7.			

Allergies: Please list the medicines to which you are allergic and tell us what happens when you take it

Medication:	**Reaction:**

Habits:
Do you smoke cigarettes? Y N How many packs per day? ____ How many years have you smoked? ____
Do you use chewing tobacco or snuff? Y N How many years have you use it? _____
Do you drink beer, wine or mixed drinks? Y N How many drinks per day do you have? _____
How many years have you drank alcohol? _____How many caffeinated drinks do you have each day? ____
Have you ever used illicit drugs (cocaine, amphetamine, marijuana, and heroin)? Y N Sometimes

Patient Name: _____ **DOB:** _____

What is the reason for your visit today?_____

Please check off any of the problems listed below if you have had them in the last six (6) months:

-Decreased hearing	-Ringing in ears	-Ear infections	-Dizzy spells
-Vision Problem	-Double vision	-Eye pain	-Nose bleeds
-Dental/gum problems	-Sinus problems	-Sore throats	-Neck swelling
-Fever/allergies	-Hoarseness	-Pneumonia	-Bronchitis
-Coughing up blood	-Asthma/wheezing	-Shortness of breath	-Chest pain
-Left arm pain	-High blood pressure	-Heart murmur	-Palpitations
-Irregular heartbeat	-High Cholesterol	-Swollen ankles	-Fainting spells
-Heart attack/angina	-Constipation	-Varicose veins	-Loss of appetite
-Difficulty swallowing	-Heartburn/indigestion	-Nausea/vomiting	-Peptic ulcers
-Diarrhea	-Diverticulitis	-Bloody/tarry stools	-Hemorrhoids
-Gall bladder trouble	-Jaundice/Hepatitis	-Hernia	-Urine Infection
-Painful urination	-Blood in urine	-Frequent urination	-Overnight urination
-Chronic fatigue	-Unplanned weight loss	-Anemia	-Easy bruising
-Cancer (including Skin)	-Always thirsty	-Always hungry	-Unplanned weight gain
-Diabetes	-Thyroid disease	- Tremor	-Stroke
-Convulsions/seizures	-Muscle weakness	-Numbness	-Headaches
-Arthritis/joint pain	-Back pain	-Bone/joint injury	-Gout
-Foot pain	-Cold feet	-Rashes	-Hives
-Eczema	-Psoriasis	-Snoring	-Sleeping difficulty
-Nervousness	-Depression	-Memory loss	-Moodiness
-Mental Illness	-Daytime sleepiness	-Do you have tattoos? ___ Blood transfusion? __	
-Control in urination	-Weak urine stream	-Urinary urgency/feeling of decreased emptying	
-Kidney stones	-Venereal disease	-Discharge from penis or vagina	
-Pelvic pain	-Erectile dysfunction	-Change in sexual drive or function	
-Change in bowel habits	-Leg pain when walking	-Blood clotting problem	

WOMEN ONLY:

Last menstrual period: _____. Do your periods come every month? Y N How often? _____
Is your flow heavy, light, or medium (circle one)? Do you get menstrual cramps? Y N
How many days does your period usually last? _____
Do you have pain or bleeding after sexual intercourse? Y N
How many times have you been pregnant? _____ How many miscarriages or abortions have you have? __
What is your method of birth control? _____.
Do you get hot flashes? Y N Do you do self breast exam? Y N
Date of your last PAP? _____. Have you ever had an abnormal PAP? Y N
When was your last mammogram? _____. Was it normal? Y N

_____ _____
Physician Signature **Date**

HEALING COMPANION MEDICAL CLINIC's
ONLINE COMMUNICATION CONSENT
3671 Broadway Blvd Ste 500
Garland, TX 75043
Phone (972)675-3818

Online communication is a form of communication using "secure" Web sites or e-mail applications that apply appropriate encryption technology designed to protect the transmission of confidential information. Online communication is an additional option for communication along with telephone, mail, and in-person. It is not meant to replace other forms of communication with the doctor.

_The details of online communication have been explained to me in terms I understand.

_Alternative methods of communication (i.e., telephone, in-person, mail) are still available to me.

_ I understand that all medical communications carry some level of risk. While the likelihood of risks associated with the use of online communication in a secure environment is substantially reduced, the risks are nonetheless real and very important to understand. These risks include, but are not limited to:

•It is easier for online communication to be forwarded, intercepted, or even changed without my knowledge.

•Online communication is easier to falsify than handwritten or signed hard copies. Backup copies may exist on a computer or in cyberspace, even after both of us have deleted our copies.

•I will use a secure network. I will not use standard e-mail or e-mail systems provided by employers. I understand that employers have a right to inspect and keep online communication transmitted through their system.

•Online communications become part of my medical record.

_ I agree to take precautions to keep online communication confidential, including but not limited to the following:

•I will keep my password confidential.

•I will not store messages on an employer-provided computer.

•I will not leave messages on my screen for others to read.

•I will review my messages before sending to make sure that they are clear and that all relevant information is included.

•I will update my contact information as soon as it changes.

_ I understand that I am responsible for taking steps to protect myself from unauthorized use of online communication. The doctor is not responsible for breaches of confidentiality caused by an independent third party or me. I authorize to release my doctor and her staffs from any responsibilities that are associated with my information being forwarded, intercepted, or even changed without my knowledge.

_ I agree to follow the procedures that the doctor implements to allow him/her to verify my identity in connection with online communication. I acknowledge that failure to comply with these procedures may terminate our online communication.
_ I understand that online communication cannot be used for emergencies or time sensitive matters.
_I understand that online communication cannot be used to communicate highly sensitive medical information, such as treatment for or information related to HIV/AIDS, sexually transmitted diseases, or addiction treatment (alcohol, drug dependence, etc.)
_I authorize to release my doctor and her staffs from any responsibilities that are associated with my information being forwarded, intercepted, or even changed without my knowledge even prior to this signing date.
_I have informed the doctor of other treatments I do not want transmitted via online communications.
_ I understand that is my responsibility to determine if an unanswered online communication was received.
_I acknowledge that I have read and fully understand this consent form, including the risks associated with the online communication.

Again, please note that online communication should never be used for emergency communications or urgent requests. These should occur via telephone or by using existing emergency communication tools.

I certify that I have read and understand this agreement and that all blanks were filled in prior to my signature.

For online communication between: _____ and all staffs and _____.
(Doctor's name)
(Patient's name)

_____ _____
Patient or Legal Representative Signature/Date/Time Relationship to Patient

_____ _____
Print Patient or Legal Representative Name Witness Signature/Date/Time

I certify that I have explained the nature of this agreement to the patient/legal representative. I have answered all questions fully, and I believe that the patient/legal representative fully understands what I have explained.

_____
Physician Signature/Date/Time

_____ copy given to patient _____ original placed in chart
initial initial