TOMBALL REGIONAL
INTERNAL MEDICINE
ASSOCIATES
13414 Medical Complex Drive, Suite 6, Tomball, TX 77375
p) 281-516-0212 f) 281-255-3320 www.tomballinternalmedicine.com

ACQUAINTANCE FORM

Please fill out completely and clearly. All information is REQUIRED. Thank you!

Name: _____ Age: _____ Birth date: _____

Mailing Address: _____ City _____ State/Zip_____

Home Address: _____ City _____ State/Zip_____

Phone (H) _____ (W) _____ (C)_____

Email: _____

Sex: M F Race: _____ Marital Status: S M D W Separated

SS #_____ Driver's License #_____

Employer _____

Address: _____ City _____ State/Zip_____

Referred By _____ Relationship _____

Emergency Contacts:

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Insurance Information:

Primary: _____ Group # _____ ID# _____

Policy Holder: _____ SS# _____ DOB _____

Employer: _____ Phone _____

Secondary: _____ Group # _____ ID# _____

Policy Holder: _____ SS# _____ DOB _____

Employer: _____ Phone _____

I assume full responsibility for payment of all service rendered not covered by my insurance plan.

I authorize payment of medical benefits to the above named provider.

I authorize the release of medical information/records to my health insurance company for the purpose of obtaining payment for services.

Signature: _____ Date: _____

TOMBALL REGIONAL

INTERNAL MEDICINE

ASSOCIATES

NAME: _____ PHYSICIAN: _____

DOB: _____ AGE: _____ APPT. DATE: _____

1. REASON FOR APPOINTMENT TODAY:

_____

2. ALLERGIES or intolerance to medications?

□ NONE (If yes, list the name of medication & what reaction it caused)

_____

_____

3. MEDICATIONS:

□ Check box if you **do not take** any prescription or over the counter medications.

□ Check box if you brought your medications, vitamins, and supplements to this appointment.

PLEASE LIST ALL MEDICATIONS AND SUPPLEMENTS THAT YOU ARE TAKING:

MEDICATION NAME	MEDICATION DOSE	HOW OFTEN (ex: once/day)

4. IMMUNIZATIONS: ENTER THE DATE OF ANY VACCINATIONS

Tetanus (Td) _____ (Tdap) _____ Influenza (flu shot) _____ TB _____

(Prevnar-13) _____ (Pneumovax-23) _____ (Prevnar-20) _____ (Zoster)_____

Shingrix (#1) _____ (#2) _____ Influenza (flu shot) _____ Hep _____

Covid-19 (*Indicate Type: **M-moderna; P-pfizer; J-J&J***) (#1) _____ (#2)_____ (#3)_____ (#4) _____

5. MEDICAL CARE TEAM:

Please list **ROUTINE** healthcare providers & their specialty: (ex: cardiologist, ophthalmologist, etc.)

NAME	SPECIALTY	PHONE / FAX / ADDRESS

List Pharmacy information and any medical suppliers you use (ex: respiratory supplies, etc):

SERVICE / DEVICE	COMPANY NAME	PHONE / FAX

6. MEDICAL FORMS: Please check any of the following forms you have completed:

□ Advance Directive for Health Care (ADHC) □ Durable Power of Attorney (DPA) for healthcare decisions
□ Living Will □ OTHER: _____

□ **Would you like more information about these forms? (circle) YES NO**

7. PERSONAL MEDICAL HISTORY: Do you have now or have you had (past) any of the following conditions?

- ☐ Alzheimer's
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune Disease
- ☐ Blood Disorder
- ☐ Bronchitis
- ☐ CAD
- ☐ Constipation
- ☐ COPD
- ☐ Crohn's Disease
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes Mellitus
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ GERD
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Murmur
- ☐ Heart Valve Replacement
- ☐ Hemorrhoids
- ☐ Hepatitis
- ☐ Hiatal Hernia
- ☐ HIV
- ☐ Hyperglycemia
- ☐ Hyperlipidemia
- ☐ Hypertension
- ☐ Hypertension
- ☐ Hypoglycemia
- ☐ IBS
- ☐ Liver Disease
- ☐ Macular Degeneration
- ☐ Migraines
- ☐ MRSA
- ☐ Multiple Sclerosis
- ☐ Osteoporosis
- ☐ Palpitations
- ☐ Pneumonia
- ☐ Polio
- ☐ Prior MI
- ☐ Prostate Problems
- ☐ PUD
- ☐ Renal Disorders
- ☐ Stroke
- ☐ Taking Blood Thinner
- ☐ Thyroid Disorders
- ☐ Tuberculosis
- ☐ Ulcerative Colitis
- ☐ Upper GI Bleeding

☐ Cancer: _____

8. SURGICAL HISTORY:

DATE: PROCEDURE

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

9. HEALTH MAINTENENCE:

	Date		*Date*		*Date*
Colonoscopy		EKG		Last Dental Exam	
Cologuard		Pacemaker Check		Last Diabetic Foot Exam	
Bone Density		Last Cervical Pap		PSA level (male)	
Mammogram		Last Vaginal Exam		HgbA1c Blood Test	
Stress Test		Last Eye Exam		Urine - MicroAlbumin	

How would you rate your health? (circle one): Excellent / Good / Fair / Poor

10. SOCIAL HISTORY:

Alcohol Use: Do you drink alcohol?

□ No □ Yes Quit date: _____
□ Less than monthly □ Less than weekly
□ 2-3 times a week □ Daily

Tobacco Use:
□ Never used tobacco □ Current User
□ Former User: Quit date: _____

Packs/day: _____ # of years: _____

Caffeine Use: Do you consume caffeine?

□ No □ Yes # of drinks/week: _____
□ Coffee □ Soda □ Tea

Drug Use: Have you ever used recreational drugs?
□ Current Use □ Past User – Year Quit: _____

If yes, which ones? _____

Exercise: Do you exercise regularly?
□ No □ Yes
If yes, what kind of exercise?

_____
_____

# of min/day: _____ # of days/week: _____

Physical Disabilities: (Please indicate below)

□ Visual Impairment □ Hearing Impairment
□ Speech Impairment □ Memory Impairment
□ Bed-bound
□ Requires assist to walk / Wheelchair dependence
□ Cardiac / Respiratory: _____
□ **None**

Activity of Daily Living: (check all that apply)

□ Independent with all daily activities
□ Difficulty feeding oneself
□ Difficulty dressing oneself
□ Difficulty bathing oneself
□ Difficulty grooming oneself
□ Difficulty with toileting needs
□ Difficulty communicating
□ Difficulty cleaning house
□ Difficulty managing money
□ Difficulty with mobility

Occupation (or prior occupation): □ Retired

_____

Education (highest level of education):

_____

Marital status:
□ Single □ Partner
□ Married □ Divorced □ Widowed

Sexual Activity: Are you sexually involved:

□ Not currently □ Never □ Yes

Birth control method or STD prevention:
(check all that apply):

□ None needed □ Condom □ Pill
□ IUD □ Patch □ Ring
□ Diaphragm □ Vasectomy
□ Tubal ligation □ Other method
(specify):_____

11. WOMEN'S HEALTH HISTORY:

Total number of pregnancies: _____ Number of births: _____ Number of miscarriages: _____

Last Menstrual Period: _____ Age at end of periods (menopause/hysterectomy): _____ Year: _____

Gestational Diabetes? (circle one) NO YES - If yes, When? _____

12. FAMILY HISTORY

Adopted? □ No □ Yes If adopted and you do not know your family history skip the Family History section and continue to Review of Symptoms on the next page.

	Year of Birth	Year of Death	Health Issues	Cause of Death
Mother				
Father				
Brother #1				
Brother #2				
Brother #3				
Sister #1				
Sister #2				
Sister #3				
Other: _____				

Diseases & Conditions	*Mother*	*Father*	*Sister(s)*	*Brother(s)*	*Notes:*
No known health problems					
Alcoholism / Drug abuse					
Alzheimer's / Dementia					
Asthma					
Autoimmune Disease					
Bleeding Disorders					
Cancer (explain)					
Depression / Anxiety					
Diabetes Type I (childhood onset)					
Diabetes Type II (adult onset)					
Emphysema (COPD)					
Genetic Disorder (explain)					
Glaucoma / Cataract					
Heart Attack, Angina (Coronary Artery Disease)					
Heart Disease (CHF)					
Hyperlipidemia – high cholesterol					
Hypertension – High blood pressure					
Kidney Disease					
Liver Disease					
Macular Degeneration					
Osteoporosis					
Stroke / TIA					
Thyroid Disease					

SYSTEM REVIEW (Current symptoms or concerns) *Check all that apply*

SYSTEMIC SYMPTOMS
- ☐ WEIGHT CHANGE
- ☐ CHILLS
- ☐ FEVER
- ☐ NIGHT SWEATS
- ☐ FEELING TIRED / POORLY

HEAD SYMPTOMS
- ☐ HEADACHE
- ☐ FACE PAIN
- ☐ SINUS PAIN

EYE SYMPTOMS
- ☐ DOUBLE VISION
- ☐ BLURRY VISION
- ☐ LIGHT SENSITIVITY
- ☐ EYE PAIN
- ☐ ITCHING EYES
- ☐ FLOATERS / BLIND SPOT
- ☐ CORRECTIVE LENSES

EAR / NOSE / MOUTH
- ☐ EARACHE
- ☐ HEARING LOSS
- ☐ RINGING IN THE EARS
- ☐ EAR DISCHARGE
- ☐ NOSE BLEED
- ☐ NASAL DISCHARGE
- ☐ MOUTH SORES
- ☐ BLEEDING GUMS
- ☐ HOARSENESS
- ☐ THROAT PAIN
- ☐ WEARS HEARING AIDES
- ☐ WEARS DENTURES
- ☐

NECK
- ☐ NECK PAIN
- ☐ NECK STIFFNESS
- ☐ LUMPS/SWELLING

BREAST
- ☐ BREAST PAIN
- ☐ NIPPLE DISCHARGE
- ☐ BREAST LUMP

CARDIOVASCULAR
- ☐ CHEST PAIN / DISCOMFORT
- ☐ FAST HEART RATE
- ☐ PALPITATIONS
- ☐ ANKLES SWELLING
- ☐ ACTIVITY INTOLERANCLE

PULMONARY
- ☐ SHORTNESS OF BREATH
- ☐ COUGH
- ☐ COUGHING UP BLOOD
- ☐ WHEEZING

GASTROINTESTINAL
- ☐ CHANGE IN APPETITE
- ☐ DIFFICULTY SWALLOWING
- ☐ HEARTBURN
- ☐ NAUSEA
- ☐ VOMITING
- ☐ ABDOMINAL PAIN
- ☐ DIARRHEA
- ☐ BLACK / TARRING STOOL

GENITAL / URINARY
- ☐ PAIN/DIFFICULT URINATION
- ☐ INCREASED FREQUENCY
- ☐ BLOOD IN URINE
- ☐ LOSS OF CONTROL

MALES:
- ☐ PENILE DISCHARGE
- ☐ ERECTION PROBLEMS
- ☐ GROIN/TESTICULAR MASS

SKIN SYMPTOMS
- ☐ ITCHING (PRURITUS)
- ☐ SKIN LESIONS
- ☐ RASHES

ENDOCRINE
- ☐ EXCESS SWEATING
- ☐ EXCESS THIRST
- ☐ LIBIDO CHANGES
- ☐ HOT / COLD INTOLERANCE

MUSCULOSKELETAL
- ☐ JOINT PAIN
- ☐ JOINT STIFFNESS
- ☐ MUSCLE ACHES
- ☐ MUSCLE WEAKNESS

NEUROLOGICAL
- ☐ DIZZINESS
- ☐ VERTIGO
- ☐ FAINTING / BLACKOUTS
- ☐ TREMORS / TWITCHES
- ☐ DIFF. MOVING ARM/LEG
- ☐ WEAKNESS
- ☐ PARALYSIS
- ☐ NUMBNESS / TINGLING
- ☐ SENSORY CHANGES (TOUCH)
- ☐ SEIZURES
- ☐ MEMORY LOSS
- ☐ CHANGES IN HAND WRITING
- ☐ BALANCE/COORDINATION

PSYCHOLOGICAL
- ☐ SLEEP TO MUCH
- ☐ DIFF. FALLING ASLEEP
- ☐ FREQ. WAKING UP
- ☐ ANXIETY
- ☐ DEPRESSION
- ☐ MOOD SWINGS
- ☐ HOPELESS

Medicare Shared Savings Program
Accountable Care Organizations

Working together to give you the best care.

Tomball Regional Internal Med. Assoc. **is part of an Accountable Care Organization (ACO). We've teamed up with other doctors, hospitals, and health care providers to make sure you get the best care.**

We provide coordinated care for you to get well & stay well

- You get patient-centered care focused on YOUR needs.
- Your health care providers can see the same test results, treatments, and prescriptions.
- More coordination helps prevent medical errors and drug interactions.
- You may save time, money, and frustration by avoiding repeated tests and appointments.
- Better communication can help protect against Medicare fraud and waste.

Get the most from your care with our communication & support

- **Ask about signing up for our secure online portal.** You'll get 24-hour access to your personal health information, including lab results and communication from your health care provider.
- When you choose a health care provider that participates in an ACO, they'll help you get the right care at the right time. You can visit **Medicare.gov** and log into (or create) your secure Medicare account to choose a primary care doctor.
- Medicare protects the privacy of your health information. If you don't want Medicare to share information with your health care providers for care coordination, call 1-800-MEDICARE (1-800-633-4227). Medicare may still share general information to measure provider quality. For more information on how Medicare may use and give out your information, visit Medicare.gov and search for "privacy."

Want more information?

Ask our front desk, or call us at 281-516-0212. You can also visit Medicare.gov or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

To report a Medicare-related concern or complaint, call 1-800-MEDICARE (1-800-633-4227).

Learn more about Accountable Care Organizations here:

CMS | MEDICARE SHARED SAVINGS PROGRAM