Terrell Clinic
Cosmetic Surgery • Aesthetic & Anti-Aging Medicine • Medical Spa

Confidential Health Questionnaire

Date:

Name:			Social Security number:		
Birthdate:	Age:	Male/Female	Marital Status:	Height:	Weight:
Address:			Cell Phone: May we leave a Message? Yes / No Home Phone: May we leave a Message? Yes / No Work Phone: May we leave a Message? Yes / No		
Email Address:			Referred By:		
Emergency Contact:			Emergency Contact Number:		
Physicians Name:			Physicians Number:		
Pharmacy Name:			Pharmacy Number:		
Employer:			Job Title:		

History

Reason for consultation: _____

Health concerns/symptoms: _____

Desired outcome of consultation: _____

Are you currently under the care of a healthcare professional for a medical condition: Yes__ No __

If yes, please describe: _____

Phone: (405) 302-0060
Fax: (405) 302-0066
5025 Gaillardia Corp. Pl., Suite E
Oklahoma City, OK 73142
Info@TerrellClinicOKC.com
www.TerrellClinicOKC.com

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Past Medical History

Please check all that apply

	YES	NO		YES	NO
Headaches/Migraines			Heart Disease		
Seizures			Chest Pain		
Sinus Infections			Irregular Heartbeat		
Seasonal Allergies			High Blood Pressure		
Emotional/Psychiatric Stress			Blood Clotting Problems		
Depression			Bleeding disorder		
Anxiety			Stroke		
Asthma			Constipation		
Chronic Bronchitis			Hepatitis		
Lung/ Breathing Problems			Kidney Disease		
Chronic Indigestion			Menstrual Disorders		
Stomach Ulcers			Reproduction Problems		
Intestinal Disease			Prostate Problems		
Skin Problems			Sexual/ Libido Problems		
Back Pain			Tendonitis		
Herniated Disk			Chronic Pain		
Neck Pain			Shoulder Problems		
Chronic Muscle/Joint Pain			Osteoarthritis		
Carpal Tunnel Syndrome			Rheumatoid Arthritis		
Fibromyalgia			Artificial Joints		
Diabetes			Cancer		
Thyroid Disease			Psoriasis		
Osteoporosis			Other- Please list below		

List any additional health problems not listed above:

_____

_____

_____

_____

_____

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Preventative Tests	Month/ Year of last treatment	Test Results
Cholesterol	----------	_____
Bone Density	----------	_____
Colonoscopy	_____	_____
Exercise Stress Test	_____	_____

List any surgeries/ operations you have had and when: _____

_____

Medication/ Supplementation

List current medications (or those you have taken within the last year).

Medication Name	Dosage	Date Started	Date Stopped

Nutritional supplements, vitamins, herbs, homeopathic remedies taken: _____

_____

Medication allergies: _____

_____

Environmental/ Food Allergies: _____

_____

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Family History

For the conditions listed, check yes or no if anyone in your family has been affected, then write the relationship of the relative with the condition/disease on the line.

Condition	NO	YES	Relationship
Heart Disease			
High Blood Pressure			
Diabetes			
Arthritis			
Skin Disorders			
Breast Cancer			
Uterine/ Ovarian Cancer			
Prostate Cancer			
Colon Cancer			
Other Cancer			

List any other disease/condition in your family and the relationship: _____

_____

MEN

Date of last prostrate exam: _____

Are you concerned with the loss of muscle mass, tone, or strength? YES NO

Have you had problems with urination? YES NO

Do you perform periodic testicular self-examinations? YES NO

Has your abdominal girth and weight been increasing? YES NO

WOMEN

Are you pregnant? YES / NO Last menstrual cycle: _____

Date of last pap/pelvic/breast exam: _____ NORMAL/ ABNORMAL

Last mammogram: _____ NORMAL/ ABNORMAL

Do you perform monthly breast self-exams? YES / NO

How many pregnancies: _____ Number of children: _____

Have you had a hysterectomy? YES / NO Were your ovaries removed? YES / NO

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Circle all that apply:

My health is: excellent good fair poor

My nutrition intake is: excellent good fair poor

My physical fitness is: excellent good fair poor

My stress level is: excellent good fair poor

Do you practice meditation/stress reducing techniques? YES NO

Dietary Habits:

- I have no special diet habits
- I avoid red meats
- I minimize fats
- I minimize carbs
- I am a vegetarian
- I emphasize fruit/veggies
- I try to eat healthy
- I avoid dairy/cheese
- I commonly eat at fast food restaurants
- I commonly eat prepackaged foods
- I commonly consume: Coffee Soft drinks Diet drinks Candy/chocolate Chips/crackers

Exercise Habits:

- No special habits
- I routinely exercise _____hours _____ times a week.
- Aerobic exercise Strength exercise/ weights Swim/dance Flexibility/yoga
- Other: _____

Tobacco History:

- I have never smoked cigarettes or chewed tobacco.
- I now smoke _____ packs of cigarettes per day. I have smoked for _____ years.
- I quit smoking in _____ (no/yr.). I smoked ____ packs/day for ____ years.
- I smoke cigars/pipe.

Alcohol History:

- I never drink alcohol.
- I drink occasionally or socially.
- I regularly drink _____ alcoholic drinks per day.
- I have a family history of alcoholism.

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HIPPA CONSENT

Date: _____

I, _____, give permission to Dr. Mendy Terrell and her medical staff to leave information pertaining to my health including but not limited to dates and times of appointments, lab or diagnostic results and other information as he/she feels necessary on my answering machine and/or email at my work or home. I understand this could result in unintentional disclosure of my personal health information.

If you have any objectives to the above, please list:

_____
_____

Phone Contact information:

Home: _____ Work: _____

Cell: _____ Other: _____

I also give permission to Dr. Terrell and/or her medical staff to discuss my health conditions with the following people:

_____	_____
Person	Relationship to patient
_____	_____
Person	Relationship to patient
_____	_____
Person	Relationship to patient

_____
Patient Signature

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Consent for Consultation

CONFIDENTIALITY STATEMENT: To ensure your complete privacy, we implement and follow specific strict security protocols and processes. We only use the highest level of customer and web site security features to guarantee your privacy and security. It is our policy to never allow any 3rd party access to any of your personal financial or medical information. If you have a question on our security processes or protocols please contact us immediately.

YOUR TEST RESULTS: You and only you receive your test results unless you direct us in writing to forward your results to a medical practitioner or an additional 3rd party. Although some positive results such as HIV are required to be reported to certain government agencies. Only the minimum required information will be reported. Your privacy is important to us and we use every care to secure your privacy rights. HIPAA, Health Insurance Portability and Accountability Act. This notice describes how medical information about you may be disclosed and how to get access to this information. Please review this carefully. In compliance with the 1996 Congressional act to protect the privacy of patients protected health information. We will safeguard all client/patient information and will disclose or share only minimal information necessary for the following purposes.

TREATMENT: Information regarding current or past health information necessary for the agency to carry out appropriate care of the clients requesting home care services which may include, but is not limited to: history and physical , progress notes, laboratory reports, x-ray reports, operative reports, consultation reports, hospital discharge reports, hospital DNR, to be obtained from any clinic, hospital , skilled nursing facility, physician office or health care agency involved in the patient/clients present and future care.

PAYMENT: Information requested by the insurance company necessary for the processing of claims for payment services.

OPERATIONS: Review of medical records by any peer review organization, accrediting body, state or regulatory body for statistical or agency evaluation purposes only. Any information disclosed will be held in strict confidence and not used for any public disclosure. If you feel that your privacy rights have been violated you may contact us and ask for the Director of Operations. The Director will investigate all claims and will provide you with a written report of their findings within 10 days if you are not satisfied with the report and the corrective action taken, the Director will provide you with an appropriate state or federal organization address and or telephone numbers to file a complaint. We will maintain a log for each patient we service which will list what information was released and for what purpose. The patient has the right to review this log upon request. Please understand that the concluded agreement determined from this consultation is non-cancelable and/or non-transferable.

Rescheduling and Cancellation Policy: A 24 hour cancellation is required. If a cancellation is less than 24 hours or you do not show for your appointment, a rescheduling fee will apply. This is for the consideration of our patients that are waiting for an appointment. We thank you for complying with this policy.

Patient Signature_____ Date_____

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