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**PATIENT INTAKE FORM**

**PATIENT INFORMATION**

Last Name: \_\_\_\_\_ MI \_\_\_\_\_ First Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Work #: \_\_\_\_\_ Ext. \_\_\_\_\_

SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Marital Status: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

E-mail: \_\_\_\_\_ How did you hear about us: \_\_\_\_\_

MINOR: \_\_\_\_\_ Parent(s) or Legal Guardian(s) name: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

**EMERGENCY CONTACT**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Work#: \_\_\_\_\_

**INSURANCE INFORMATION**

Insurance Primary Carrier: \_\_\_\_\_ Phone #: \_\_\_\_\_

Insured: \_\_\_\_\_ Group #: \_\_\_\_\_ Policy #: \_\_\_\_\_

Insurance Secondary Carrier: \_\_\_\_\_ Phone #: \_\_\_\_\_

Insured: \_\_\_\_\_ Group #: \_\_\_\_\_ Policy #: \_\_\_\_\_

**ASSIGNMENT OF INSURANCE INFORMATION & BENEFITS**

I hereby authorize the insurance carrier listed above to make payments directly to the Health Care Provider and understand that I am financially responsible for all charges incurred that are not covered in full by my insurance. I further understand that if I enroll in another insurance plan, it is my responsibility to notify the Health Care Provider; otherwise I will be responsible for payment.

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Thank You!

Personal Medical history: page 1

Today's date: \_\_\_\_\_

Patient name: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_

**Past medical history: Please check all conditions you have ever been diagnosed with. Explain details below the check off list, please. Include whether problem is past or current and approximate date of onset.**

Hypertension \_\_\_ Diabetes \_\_\_ Heart disease \_\_\_ Heart attack \_\_\_ Liver disease \_\_\_ Kidney disease \_\_\_  
Lung disease \_\_\_ Asthma/COPD \_\_\_ Cardiovascular disease \_\_\_ Cerebrovascular disease \_\_\_ Stroke \_\_\_  
TIA \_\_\_ Cancer \_\_\_ GERD \_\_\_ Hepatitis \_\_\_ Osteoporosis \_\_\_ Arthritis \_\_\_ Seizure disorder \_\_\_  
Thyroid disorder \_\_\_ Bleeding disorder \_\_\_ Infectious disease \_\_\_ Breast disease \_\_\_ Anemia \_\_\_  
Transfusions \_\_\_ Anxiety \_\_\_ Depression \_\_\_ Other psychiatric \_\_\_

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**Past Surgical history: Check all that apply. Include procedures not on the check off list below. Explain details. Give approximate surgery dates and any complications.**

Tonsillectomy \_\_\_ Appendectomy \_\_\_ Gallbladder \_\_\_ Hernia \_\_\_ Hysterectomy \_\_\_ C-section \_\_\_  
Back surgery \_\_\_ Knee surgery \_\_\_ Hip surgery \_\_\_ Other orthopedic surgery \_\_\_

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**Hospitalizations: approximate dates, reason**

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**Current prescription medications: list names, strength, dosage interval reason for taking and duration of use:**

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Personal Medical history: page 2

Today's date: \_\_\_\_\_

Patient name: \_\_\_\_\_

**Current over the counter medications: list names, strength, dosage interval reason for taking and duration of use:**

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Current vitamins, minerals, herbs, remedies or other supplements currently being taken : list names, strength, dosage interval reason for taking and duration of use:

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**Allergies: Check all that apply.**

No known drug allergies \_\_\_\_

Medication \_\_\_\_

Environmental \_\_\_\_

Foods \_\_\_\_

Latex \_\_\_\_

Intravenous contrast dye \_\_\_\_

Other \_\_\_\_

Details of above allergies:

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**Reproductive history**

**Females:**

Age at onset of menses \_\_\_\_\_ Still menstruating \_\_\_\_ First day of last menses (date) \_\_\_\_\_

Interval between cycles (indicate days or weeks) \_\_\_\_\_ Duration of flow \_\_\_\_\_

Quality of flow heavy \_\_\_\_ medium \_\_\_\_ lite \_\_\_\_ very lite \_\_\_\_

Check all that apply: cycles regular \_\_\_\_ irregular \_\_\_\_ severe cramping \_\_\_\_ bleeding between cycles

\_\_\_\_ PMS \_\_\_\_

Personal Medical history: page 3

Today's date: \_\_\_\_\_

Patient name: \_\_\_\_\_

**Reproductive history (continued)**

Number of pregnancies \_\_\_\_\_ Number of live births \_\_\_\_\_ Number of miscarriages \_\_\_\_\_ Number of abortions \_\_\_\_\_

Birthing complications: \_\_\_\_\_

Menopause: Age at onset \_\_\_\_\_ Abnormal vaginal bleeding since? Yes/No

Symptoms: \_\_\_\_\_

Hormones/herbs/supplements: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Males and Females answer the following:**

I prefer not disclosing sexual related information \_\_\_\_

Sexually active Yes/No

Contraception method: \_\_\_\_\_

Check all that apply: same sex partner \_\_\_\_ opposite sex \_\_\_\_ abstinent \_\_\_\_ single partner \_\_\_\_

multiple partners \_\_\_\_ greater than 4 lifetime partners \_\_\_\_

Sexually transmitted infection history: None/or as noted:

\_\_\_\_\_

Any sexually related concerns Yes/No