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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 ___

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 ___

Hospitalizations: approximate dates, reason

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

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:

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

Allergies: Check all that apply.

No known drug allergies

Medication

Environmental

Foods

Latex

Intravenous contrast dye

Other

Details of above allergies:

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