CLINICA DIANA (210) 495-9950

Patient Information as of _______________ (enter today's date)
(Please Print Legibly & Fill In or Correct All Fields)

Patient's Name ____________________
First Middle Last ID

Address ____________________ San Antonio Tx ____
Street & Apt # City State Zip

Home Phone ____________ Cell Phone ____________ Other Phone ____________

Any restrictions for contacting you? ❒ No ❒ Yes, if so, which phone?__________ E-mail ____________

Contact Preference : which number is best to reach during the day? ____________

Age ______ Birthdate __________ SS# __________ Gender ❒ Female ❒ Male

Marital Status ❒ Single ❒ Married to: ____________ ❒ Other: ____________

Patient's Employer ____________ Occupation ____________

Work Phone ____________ Ext: ______ Is it okay to call you at work? ❒ Yes ❒ No

Address ____________________
Street & Suite # City State Zip

How did you hear about Dr. Diana? (Mark all that apply)

❒ TV News ❒ TV Ad ❒ Phone Book ❒ Magazine ❒ Newsletter ❒ Seminar ❒ Salon ❒ Web

❒ Friend/Relative: ____________ ❒ Doctor: ____________ ❒ Other: ____________

If you were referred by a specific person, may we thank them? ❒ Yes ❒ No

Contacts: Names of those that we may speak with if we are unable to reach you: ____________ ____________ ____________

Emergency Contact
(Not in your household) ____________ Relationship to Patient ____________

Home Phone ____________ Work Phone ____________ Other Phone ____________

Primary Health Insurance Company ____________

Policy # ____________ Group # ____________ Ins. Phone ____________

Referral Required? ❒ No ❒ Yes Copay? ❒ No ❒ Yes, $ ________

Insured: Name ____________ DOB ____________ Employer ____________

I understand that office visit charges are payable on the day service is rendered. I authorize Dr. Diana to bill my insurance company for medically necessary services. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Dr. Diana and myself.

Signature ____________________ **Date** ____________

Reason for your visit:

____
____
____

Consult

____

Please list all medications which you are currently taking or have used in the past 6 months (be sure to include any of the following: birth control pills, aspirin or ibuprofen containing drugs, diet pills, diabetic medications, steroids, glaucoma drops, asthma medications, Digoxin, Lanoxin, nitroglycerin, Isordil, Inderal, other heart medications, Lasix, other diuretics, high blood pressure medications, Coumadin, Persantine, tranquilizers, sleeping pills, anti-depressants, pain pills or shots, epilepsy medications).

Medication(s): **Amount** **Frequency**

____
____
____
____
____

List all drug allergies:____

Have you ever used (circle): LSD/speed/cocaine/marijuana? Never

Are you a smoker**? YES/NO** Ex-Smoker **YES/NO** Non-Smoker

How much are/were you smoking?____ How long?______________ Quit how long ago?_________

How much alcohol do you drink?________________________________ Caffeine?_________________

Please circle all of the following medical conditions you now have or have had in the past:_____________

bleeding tendency	stroke	wheezing	Hepatits A B C
blood transfusions	mental illness	emphysema	heart burn
diabetes	depression	bronchitis	intestinal ulcers/bleeding
irregular heart beat	drug/alcohol addiction	lung disease	chest pain
epilepsy	TB	heart disease	glaucoma/dry eyes
asthma	heart attack	hypertension	HIV/Aids

any other serious illness or injury________________ **None of the above**

Cancer: **YES/NO** List type:______________________

List all surgeries that you have had (include plastic surgery):________________ Date:__________

____ ______________
____ ______________
____ ______________
____ ______________

Have you or anyone in your family ever had an unusual reaction to anesthesia (muscle weakness, jaundice, breathing problems or unexpected fevers)? **YES/NO**

Have you ever had a problem or reaction to any of the following:

Local anesthetics Adhesive tape Antibiotics Pain killers Iodine Latex Powdered Gloves

None of the Above

Do you have a family history of Breast Cancer? **YES/NO**

Last mammogram date:____________ Normal: **YES/NO**

Are you pregnant? **YES/NO** Number of children:______

Date of last period:________________

Name of Family Doctor:___________________________ Date of last check up:___________________

Have you ever seen a cardiologist? **YES/NO** Physician's Name:________________________

Date of last EKG:_________________

Patient Signature:________________________________ Date:_________________