

Mark Jacobs, MD, P.A.



7580 Fannin, Suite 220
(Phone) 713-799-2515

Houston, Texas 77054
(Fax) 713-799-2564

Please Fill Out Completely:

Pharmacy Phone No. _____

Patient Name: _____ Date: _____

Age: _____ Number of Pregnancies: _____ Number of Children: _____

Medications you are taking: _____

Allergies: _____

Last Menstrual period: _____ Cycles: Regular _____ Irregular: _____ Method of Contraception: _____

Reason for Visit: _____

Have you been treated for any of the following (circle all applicable)

Seizure or epilepsy

Stroke

Migraines

Thyroid disease

Heart problems or murmurs

Asthma or pneumonia

Tuberculosis

Ulcers or reflux

Hepatitis

Colon Problems

Intestinal disease

Gallbladder disease

Kidney disease

Kidney stones

Urinary infection

Arthritis

Skin problems

Lupus

Cancer

Blood clots

Glaucoma

High blood pressure

High cholesterol

Diabetes

List any surgeries you have had: _____
Do you have a family history of: *Diabetes, heart attack, stroke, high blood pressure, kidney disease, birth defects, inherited disease, cancer (Circle all applicable)*

General medical checkup/heart: _____ Colonoscopy: _____

Please answer the following:

Do you perform breast Self-examination?	Y / N	Do you exercise?	Y / N
Do you feel any lumps?	Y / N	Walk the equivalent of one mile per day?	Y / N
Do you smoke? How Much?	Y / N	Do you take vitamins?	Y / N
Do you drink alcohol? How Much?	Y / N	Do you take Calcium? Y / N Vitamin D?	Y / N

Do not fill out below this line

Physical Exam: BP _____ Pulse _____ Height _____ Weight _____ Temp _____ UPT _____ VAG: pH _____ KOH _____ Wet _____

HEENT:	Pelvic:
Neck:	Ext. Genitalia:
Thyroid:	Urethra:
Chest:	Vagina:
Heart:	Cervix:
Breasts:	Uterus:
Abdomen:	Adnexa:
Extremities:	Ano-Rectal
DX:	Lab:
	RX:

Mark Jacobs, MD

Patient Information

Name (First) _____ (M.I) _____ (Last) _____

Date of Birth _____ Age _____ Marital Status _____

Address _____

City _____ State _____ Zip Code _____

Best Daytime Phone # _____ **Social Security #** _____

Employer _____ Work # _____

Email _____

Referring Physician _____

Emergency Contact: _____

Responsible Party

Name _____ Relationship to Patient _____

Address _____

City _____ State _____ Zip Code _____

Date of Birth (Insured) _____ Social Security # _____

Work Phone # _____ Cell # _____

Employer _____

Employer Address _____

Insurance Information

Insurance Company _____ Phone # _____

Member ID # _____ Group # _____

Claims Address _____

Insured Name _____

Relationship to Patient _____

I hereby assign, transfer, and set forth to Mark Jacobs, MD,PA all of my right, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Patient Signature _____ Date _____

Patient Signature _____ Date _____

No changes to the information provided above