Dr. Wendy M. Merola
901 Cypress Creek Rd. Bldg. 1, Ste. 100
Cedar Park, Texas 78613

Name:_____ Today's Date:_____
First Middle Last

Home Address:_____
City:_____ State:_____ Zip:_____
Home Phone( )_____ Cell Phone ( )_____
Birth date:_____ Age:_____ SSN:_____
Employer:_____
Employer's Address_____
City:_____ State:_____ Zip:_____ Occupation:_____
Work Phone ( )_____

[Primary Insurance]
Name of Insurance Company: _____
Address: _____
City: _____ State: _____ Zip: _____
Insured's Name: _____
Group Number: _____ Policy ID Number: _____

[Secondary Insurance]
Name of Insurance Company: _____
Address: _____
City: _____ State: _____ Zip: _____
Insured's Name: _____
Group Number: _____ Policy ID Number: _____

Our office will file insurance for all reimbursable services, to both your primary & secondary insurance carriers. Please note that you are responsible for all deductible, copays, and non-covered amounts.

Consent to Treat
I (or my legal guardian or parent) authorize Wendy Merola, MD, to provide medical care reasonable by today's standards. Signature of Patient/Legal Guardian:_____

Notice of Privacy Practices/HIPPA

Please read the laminated sheets & sign below.

Patient Name: _____ Date of Birth: _____

Signature of Patient/Legal Guardian: _____

Family Practice New Patient Intake Form

Reason for Visit_____

Past Medical History:

Please review the list below and check any problems you have had now or in the past

Abnormal Pap Smear		Eczema		Osteopenia	
Acne		Emphysema		Osteoporosis	
ADD/ADHD		Frequent UTI's		Positive TB Skin Test	
Alcohol Abuse		Freq Sinus Infections		Prostate Problems	
Anemia		Gallstones		Psoriasis	
Anxiety Disorder		Glaucoma		Reflux (heartburn)	
Asthma		Gout		Rheumatoid Arthritis	
Bipolar Disorder		Heart Attack		Rosacea	
Blood Clot		Heart Condition (specify)		Seasonal Allergies	
Blood Transfusion		Hepatitis (specify A, B, C)		Seizures	
Cancer (What kind)		High Blood Pressure		Sexually Trans. Disease (specify)	
Chronic Bronchitis		High Cholesterol		Stomach Ulcers	
Crohn's Disease or IBS		Kidney Disease		Stroke	
Colon Polyps		Kidney Infections		Tuberculosis	
Depression		Kidney Stones		Thyroid Disease	
Diabetes		Lupus		Ulcerative Colitis	
Diverticulitis		Melanoma or Skin Cancer		Warts	
Drug Abuse		Migraines			
Eating Disorder		Osteoarthritis			

Other medical problem not on list:_____

Please check or list all of the **SURGERIES** you have had:

	Type of surgery:	**Year**
	Appendectomy	
	Arthroscopy (joint)	
	Back or Neck Surgery	
	Cataract Surgery	
	Cesarean Section	
	Gallbladder Removal	
	Heart Surgery (specify)	
	Hemorrhoids	
	Hernia	

	Type of surgery:	**Year**
	Hysterectomy	
	Knee or Hip Replacement	
	Mastectomy or Lumpectomy	
	Mastectomy/Lumpectomy	
	Polyp Removal (colon)	
	Tonsillectomy/Adenoidectomy	
	Tubal Ligation or Vasectomy	
	Plastic Surgery (specify)	
	Other (specify)	

Current Medications:(please include over the counter medications and food supplements)

Drug Name:	Dose:	How Often?

Drug Name:	Dose:	How Often?

Are you **ALLERGIC** to any medications? **Yes No**

Drug Name:	Reaction:

NAME: _____

Health Maintence:

Last menstrual period	/ /
Last pap smear n/a	/ /
Last mammogram n/a	/ /
Last bone density	/ /
Last colonoscopy	/ /

Last tetanus shot	
Last flu shot	
Last pneumonia shot	
Age of first period	
Are you menopausal	Y N

# of pregnancies	
# of live births	
# of miscarriages	
# of abortions	
# of living children	

Family History: Have any of your family members had any of the following problems?

X	Condition:	Family Member:
	Heart Disease/attack	
	Stroke	
	Diabetes	
	High Blood Pressure	
	High Cholesterol	
	Thyroid Disease	
	Depression	
	Other Mental Illness	
	Alcoholism	
	Asthma	

X	Condition:	Family Member:
	Osteoporosis	
	Migraines	
	Breast Cancer	
	Colon Cancer	
	Prostate Cancer	
	Lung Cancer	
	Ovarian Cancer	
	Uterine Cancer	
	Skin Cancer	
	Other Cancer	

Any other illness in the family not listed? _____

Social History:

Marital Status (circle one): Single Engaged Married Separated Divorced Widowed
Highest Level of Education: <6th grade Jr. High High School College Graduate school Professional
Occupation: _____
If you have any children, please list their names and ages: _____

Health Habits:

1. Do you **smoke currently?** **Yes No** If so, how much? ___ cig/d # of years smoking ___
   If no, did you **smoke in the past?** **Yes No** How many years? __ How much? ___pk/d quite date _____
   Are you **exposed to smoke?** **Yes No**
   Any other **tobacco use?** **Yes No** type: **Cigars chewing tobacco snuff other**
2. Do you drink **Alcohol?** **Yes No** What kind? Beer Wine Liquor Other:_____
   If so, how many drinks per week? _____ month? _____ year? _____
   Have you ever had a social or legal problem with alcohol? Yes No
3. Have you ever used **street drugs? Yes No**
   Which ones? Marijuana IV drugs amphetamines cocaine heroin downers inhalants other _____
   Are you still using? **Yes No** Which ones? _____
4. Have you been **sexually active** in the last year? **Yes No**
   Please circle all that apply: **1 partner multiple partners**
   sexual orientation: **Heterosexual Homosexual**
   Which birth control do you or your partner use? None condoms the pill vasectomy/tubal other_____
5. Do you **exercise? Yes No** If so, what type and how often? _____
6. Do you have an advanced medical directive? Yes No If yes, please provide a copy to Dr. Merola.

NAME: _____