TED L. EDWARDS, JR., M.D.
4201 Bee Caves Road, Suite B-112; Austin, Texas 78746

INTERNAL USE ONLY. DO NOT COMPLETE

SCANNED _____

MEDICAL HISTORY

PATIENT NAME _____ DATE _____

CURRENT MEDICAL CONDITION

Please describe why you came to see the doctor.

_____ DATE PROBLEM BEGAN _____

_____ DATE PROBLEM BEGAN _____

_____ DATE PROBLEM BEGAN _____

FOR WOMEN ONLY

I wish to have a nurse in the exam room when the doctor examines my chest. YES ☐ NO ☐ DOESN'T MATTER ☐

ALLERGIES

Yes/No		Reaction	Start Date
☐	*NONE*		
MEDICATION ALLERGIES			
☐ ☐	Aspirin		/
☐ ☐	Codeine		/
☐ ☐	Morphine		/
☐ ☐	Penicillin		/
☐ ☐	Sulfa		/
☐ ☐	X-Ray Dye		/
FOOD ALLERGIES			
☐ ☐	Eggs		/
☐ ☐	Peanuts		/
☐ ☐	Shellfish		/
ENVIRONMENTAL ALLERGIES			
☐ ☐	Dust		/
☐ ☐	Grass		/
☐ ☐	Molds		/
☐ ☐	Ragweed		/
☐ ☐	Animals		/
☐ ☐	Cedar		/
☐ ☐	Fire Ants		/
☐ ☐	Flying Insects		/
OTHER			
			/

☐ *See attached for more*

MEDICATIONS

Name	Dosage	Frequency

PRESCRIPTION MEDICATION

OVER THE COUNTER MEDICATION

SUPPLEMENTS

☐ *See attached for more*

SURGERIES

Yes/No		*Type	Year
☐ ☐	Tonsils		/
☐ ☐	Appendix		/
☐ ☐	Gallbladder		/
☐ ☐	Stomach*		/
☐ ☐	Kidney*		/
☐ ☐	Colon*		/
☐ ☐	Thyroid		/
☐ ☐	Hernia		/
☐ ☐	Breast*		/
☐ ☐	Uterus		/
☐ ☐	Ovaries*		/
☐ ☐	Prostate		/
☐ ☐	Joint Replacement		/
☐ ☐	Amputation*		/
☐ ☐	Tubal Ligation		/
☐ ☐	Vasectomy		/
☐ ☐	C-Section		/
☐ ☐	Hysterectomy		/
☐ ☐	Hemorrhoidectomy		/
☐ ☐	Other		/
☐ ☐	Other		/
☐	*See attached for more*		

GENERAL

- ☐ ☐ Changes in appetite
- ☐ ☐ Changes in thirst
- ☐ ☐ Changes in weight
- ☐ ☐ Changes in energy level

HEAD

- ☐ ☐ Headaches
- ☐ ☐ Migraines
- ☐ ☐ Tension
- ☐ ☐ TMJ
- ☐ ☐ Dental problems
- ☐ ☐ Injury

EYES

- ☐ ☐ Visual difficulty
- ☐ ☐ Double vision
- ☐ ☐ See color halos
- ☐ ☐ Contacts
- ☐ ☐ Glasses
- ☐ ☐ Cataracts
- ☐ ☐ Glaucoma
- ☐ ☐ Injury

EARS

Yes/No

- ☐ ☐ Hearing difficulty
- ☐ ☐ Chronic ear infection
- ☐ ☐ Tubes
- ☐ ☐ Hearing aids
- ☐ ☐ Ringing
- ☐ ☐ Loss of balance
- ☐ ☐ Injury

NOSE

- ☐ ☐ Polyps
- ☐ ☐ Sinusitis
- ☐ ☐ Allergies
- ☐ ☐ Nosebleeds
- ☐ ☐ Injury

LUNGS

- ☐ ☐ Tuberculosis
- ☐ ☐ Pneumonia
- ☐ ☐ Asthma
- ☐ ☐ Emphysema
- ☐ ☐ Pleurisy
- ☐ ☐ Cough
- ☐ ☐ Cough up blood
- ☐ ☐ Shortness of breath
- ☐ ☐ Chronic bronchitis
- ☐ ☐ Cancer
- ☐ ☐ Smoker
- ☐ ☐ Secondhand smoke
- ☐ ☐ Chest x-ray Date: _____

HEART/CIRCULATORY

- ☐ ☐ High blood pressure
- ☐ ☐ Chest pain
- ☐ ☐ Heart murmur
- ☐ ☐ Heart disease
- ☐ ☐ Abnormal EKG
- ☐ ☐ Rapid heart beat
- ☐ ☐ Heart attack
- ☐ ☐ Varicose veins
- ☐ ☐ Phlebitis
- ☐ ☐ Blood transfusions
- ☐ ☐ Bruise easily
- ☐ ☐ Anemic
- ☐ ☐ Pacemaker
- ☐ ☐ Heart surgery
- ☐ ☐ Swelling of ankles or feet

TED L. EDWARDS, JR., M.D.
4201 Bee Caves Road, Suite B-112; Austin, Texas 78746

INTERNAL USE ONLY DO NOT COMPLETE

SCANNED _____

MEDICAL HISTORY

PATIENT NAME _____ DATE _____

GASTRO-INTESTINAL
Yes/No

- ☐ ☐ Digestive problems
- ☐ ☐ Heartburn
- ☐ ☐ Ulcers
- ☐ ☐ Nausea/vomiting
- ☐ ☐ Diarrhea
- ☐ ☐ Hemorrhoids
- ☐ ☐ Bloody stools
- ☐ ☐ Constipation
- ☐ ☐ Black bowl movement
- ☐ ☐ Gallbladder disease
- ☐ ☐ Rectal bleeding
- ☐ ☐ Anorexia/Bulimia
- ☐ ☐ Colostomy

GENITO-URINARY

- ☐ ☐ Chronic urinary tract infections
- ☐ ☐ Urinary problems
- ☐ ☐ Kidney stones
- ☐ ☐ Gonorrhea
- ☐ ☐ Syphilis
- ☐ ☐ Herpes
- ☐ ☐ Chlamydia
- ☐ ☐ Other:

_____

_____

MUSCLE/BONE

- ☐ ☐ Painful/swollen joints
- ☐ ☐ Back pain
- ☐ ☐ Back injury
- ☐ ☐ Arthritis
- ☐ ☐ Disease of the muscle or joint
- ☐ ☐ Muscle spasms
- ☐ ☐ Bursitis
- ☐ ☐ Tendinitis
- ☐ ☐ Gout
- ☐ ☐ Carpal Tunnel Syndrome
- ☐ ☐ Injury, Type: _____

LIVER

- ☐ ☐ Jaundice
- ☐ ☐ Hepatitis
- ☐ ☐ Cancer
- ☐ ☐ Cirrhosis

BLOOD

- ☐ ☐ Anemic
- ☐ ☐ Clotting problems
- ☐ ☐ High blood sugars
- ☐ ☐ Low blood sugars
- ☐ ☐ Contact w/ blood products
- ☐ ☐ Transfusion(s)
- ☐ ☐ HIV+
- ☐ ☐ Hepatitis

NEUROLOGICAL
Yes/No

- ☐ ☐ Seizures/Convulsions
- ☐ ☐ Parkinson's disease
- ☐ ☐ Fainting spells
- ☐ ☐ Stroke
- ☐ ☐ Cerebral hemorrhages
- ☐ ☐ Loss of consciousness
- ☐ ☐ Paralysis
- ☐ ☐ Cancer
- ☐ ☐ Brain Tumor
- ☐ ☐ Alzheimer's disease
- ☐ ☐ Attention Deficit Disorder

SKIN

- ☐ ☐ Cancer
- ☐ ☐ Psoriasis
- ☐ ☐ Eczema
- ☐ ☐ Dry skin
- ☐ ☐ Loss of pigment
- ☐ ☐ Moles
- ☐ ☐ Warts
- ☐ ☐ Rashes
- ☐ ☐ Bruising or bleeding
- ☐ ☐ Ulcers

OTHER

- ☐ *See attached for more*

GENDER RELATED/FEMALE

- ____ Number of pregnancies
- ____ Number of premature births
- ____ Number of live births
- ☐ ☐ Complications of pregnancy, Type:

_____

- ☐ ☐ C-section
- ☐ ☐ Abortion
- ☐ ☐ Birth control pills
- ☐ ☐ Use estrogen/progesterone
- ☐ ☐ Tubal ligation
- ☐ ☐ Other birth control, Type:

_____

- ____ Age menses started
- ____ Age menses stopped
- ☐ ☐ Abnormal periods
- ☐ ☐ PMS
- ☐ ☐ Endometriosis
- ☐ ☐ Hysterectomy, Type: _____
- ☐ ☐ Vaginal infections
- ☐ ☐ Vaginal discharge
- ☐ ☐ Vaginal dryness
- ☐ ☐ Cancer, Type: _____
- ☐ ☐ Hot flashes
- ☐ ☐ Night sweats
- ☐ ☐ Ovarian cysts
- ☐ ☐ Breast lumps/discharge
- ☐ ☐ Fibrocystic disease
- ☐ ☐ Self breast exams
- ☐ ☐ Pap Smear Date: _____
- ☐ ☐ Mammogram Date: _____

GENDER RELATED/MALE
Yes/No

- ☐ ☐ Penile discharge
- ☐ ☐ Swelling of groin
- ☐ ☐ Difficulty urinating
- ☐ ☐ Epididymitis
- ☐ ☐ Difficulty with erection
- ☐ ☐ Impotence
- ☐ ☐ Cancer, Type: _____
- ☐ ☐ Vasectomy
- ☐ ☐ Swelling of scrotum
- ☐ ☐ Pain or lumps in testicles
- ☐ ☐ Prostate disease

LIFESTYLE

☐ Married ☐ Widowed ☐ Divorced ☐ Single

____ Number of children living at home

Ages: _____

____ Number of others living at home

Type of work: _____

Level of stress: _____

- ☐ ☐ Caffeine use: _____ per day
- ☐ ☐ Alcohol use: _____ per week
- ☐ ☐ Tobacco use: _____ per day
- ☐ ☐ Substance use: _____ per week
- ☐ ☐ Victim of abuse

EXERCISE

Type: _____

Minutes and times per week

_____

HISTORY OF TRAUMA

Yes/No		Date
☐ ☐	Head: Concussion	_____
☐ ☐	Head: Laceration	_____
☐ ☐	Head: Closed Injury	_____
☐ ☐	Facial: Eye	_____
☐ ☐	Facial: Ear	_____
☐ ☐	Facial: Nose	_____
☐ ☐	Facial: Jaw	_____
☐ ☐	Neck: Fracture	_____
☐ ☐	Neck: Injury	_____
☐ ☐	Shoulder/Clavicle: Fracture	_____
☐ ☐	Shoulder/Clavicle: Dislocation	_____
☐ ☐	Arm: Fracture	_____
☐ ☐	Arm: Dislocation	_____
☐ ☐	Hand/Fingers: Fracture	_____
☐ ☐	Hand/Fingers: Dislocation	_____
☐ ☐	Torso: Rib Fracture	_____
☐ ☐	Torso: Chest Injury	_____
☐ ☐	Torso: Cardiac Injury	_____
☐ ☐	Torso: Organ Trauma	_____
☐ ☐	Torso: Back Injury	_____
☐ ☐	Genitalia: Trauma	_____
☐ ☐	Leg: Fracture	_____
☐ ☐	Leg: Amputation	_____
☐ ☐	Leg: Laceration	_____
☐ ☐	Leg: Dislocation	_____
☐ ☐	Foot/Ankle: Fracture	_____
☐ ☐	Foot/Ankle: Amputation	_____

TED L. EDWARDS, JR., M.D.
4201 Bee Caves Road, Suite B-112; Austin, Texas 78746

INTERNAL USE ONLY DO NOT COMPLETE

SCANNED _____

MEDICAL HISTORY

PATIENT NAME _____ DATE _____

MENTAL STATUS

Yes/No

- ☐ ☐ Nervous
- ☐ ☐ Depressed
- ☐ ☐ Trouble making decisions
- ☐ ☐ Anxious or uneasy
- ☐ ☐ Sexual problems
- ☐ ☐ Bored
- ☐ ☐ Thoughts of suicide
- ☐ ☐ Need to talk
- ☐ ☐ Panic or desperation
- ☐ ☐ Recent changes in lifestyle
- ☐ ☐ Other:

_____

_____

IMMUNIZATIONS

Yes/No — Date of Last Immunization

- ☐ ☐ Flu _____
- ☐ ☐ Pneumonia _____
- ☐ ☐ Rubeola _____
- ☐ ☐ Rubella _____
- ☐ ☐ Mumps _____
- ☐ ☐ MMR (Measles/Mumps/Rubella) _____
- ☐ ☐ TB Test _____
- ☐ ☐ Polio _____
- ☐ ☐ DPT (Diphtheria/Pertussis/Tetanus) _____
- ☐ ☐ DT (Diphtheria/Tetanus) _____
- ☐ ☐ Hepatitis A _____
- ☐ ☐ Hepatitis B _____
- ☐ ☐ Other:

_____

PROSTHESIS

Yes/No

- ☐ ☐ Artificial Joints
- ☐ ☐ Dentures
- ☐ ☐ Hearing Aid(s)
- ☐ ☐ Pacemaker
- ☐ ☐ Implants
- ☐ ☐ Transplants
- ☐ ☐ Other:

_____

_____

FAMILY HISTORY

Please indicate with a check each family member living. Indicate the family member's present age or age at time of death. Indicate with a check any of the diseases from which family members suffer(ed). If the disease is a specific type, please write the type in the box (i.e., Cancer — Breast). Other diseases not listed may be hand written in the space provided.

			MOTHER'S		FATHER'S	
	MOTHER	FATHER	MOTHER	FATHER	MOTHER	FATHER
Check if Living						
Age: Living or at death						
Alcoholism						
Allergies						
Alzheimer's Disease						
Arthritis						
Blood/Circulation						
Depression						
Cancer						
Diabetes						
Digestive System						
Drug Sensitivities						
Eye Disorder						
Heart Disease						
Hearing Disorder						
Hypertension						
Kidney Stones						
Liver Disorder						
Musculoskeletal						
Reproductive System						
Respiratory System						
Scoliosis						
Stroke						
Tuberculosis						
Ulcer Disease						
Urinary/Prostate						
Other:						

TED L. EDWARDS, JR., M.D.
4201 Bee Caves Road, Suite B-112; Austin, Texas 78746

INTERNAL USE ONLY DO NOT COMPLETE

SCANNED _____

MEDICAL HISTORY

PATIENT NAME _____ DATE _____

ADDITIONAL INFORMATION

Please use the space below for comments and additional information. If applicable, please note the section to which the comment refers.

TED L. EDWARDS, JR., M.D.
4201 Bee Caves Road, Suite B-112
Austin, Texas 78746

PATIENT REGISTRATION FORM

DATE: _____

Please Print Legibly

PATIENT INFORMATION

LAST NAME	FIRST NAME		M.I.
ADDRESS			APT/UNIT
CITY	STATE		ZIP
HOME PHONE ( )	WORK PHONE ( )		OTHER ( )
DATE OF BIRTH (MM/DD/YYYY)	[ ] MALE [ ] FEMALE	SOCIAL SECURITY NUMBER	DRIVER'S LICENSE NUMBER STATE
EMPLOYER NAME AND ADDRESS			
E-MAIL ADDRESS		SPOUSE/SIGNIFICANT OTHER (NAME)	
NEXT OF KIN	RELATIONSHIP		PHONE ( )

IN CASE OF EMERGENCY, PLEASE CONTACT

CONTACT # 1	RELATIONSHIP	DAY PHONE ( ) NIGHT PHONE ( )
CONTACT # 2	RELATIONSHIP	DAY PHONE ( ) NIGHT PHONE ( )

PAYMENT INFORMATION

HOW DO YOU PLAN TO PAY FOR YOUR VISIT TODAY? [ ] CASH [ ] CHECK [ ] CREDIT CARD		RESPONSIBLE PARTY [ ] SELF [ ] SPOUSE [ ] OTHER
PRIMARY INSURANCE CARRIER	ID NO.	GROUP NO.
SECONDARY INSURANCE CARRIER	ID NO.	GROUP NO.

CONTACT INFORMATION

PRIMARY PHARMACY	PHONE ( )	FAX ( )
SECONDARY PHARMACY	PHONE ( )	FAX ( )

MISCELLANEOUS

WEIGHT	HEIGHT	HAIR COLOR	EYE COLOR	BLOOD TYPE
ORGAN DONOR [ ] YES [ ] NO		LIVING WILL [ ] YES [ ] NO	LANGUAGES (S) SPOKEN	
RELIGIOUS PREFERENCE			HIGHEST LEVEL OF EDUCATION	

INSURED PARTY'S INFORMATION (if same as above do not complete)

LAST NAME	FIRST NAME		M.I.
ADDRESS			APT/UNIT
CITY	STATE		ZIP
HOME PHONE ( )	WORK PHONE ( )		OTHER ( )
SOCIAL SECURITY NUMBER	DATE OF BIRTH (MM/DD/YYYY)		EMPLOYER

ADDITIONAL PHYSICIANS

Please lis below all other physicians you are currently seeing for any reason.

Reason/Problem	Physician or Medical Facility	City. State

RELEASE OF MEDICAL RECORDS

If you wish for us to provide your records or information pertaining to your appointments, to someone other than yourself, please list name (s) below.

NAME: _____

NAME: _____

CONSENT

I understand I am responsible for the payment of all services rendered by Ted L. Edwards, Jr., M.D., P.A., at the time service is performed unless arrangements are made with the office manager. I may be subject to a $ 50.00 minimum NO SHOW fee should I fail to give a 24-hour cancellation notice. By my signature, I consent to treatment.

I authorize the release of any medical records or other information necessary in order to process this claim with my insurance company and/ or attorney. This further authorizes payment be made directly to the physician.

To assure that my healthcare providers have comprehensive up-to-date medical records, I authorize Critical Connection, Inc. to release my medical records, including all future updates, to all my healthcare providers named above, unless otherwise noted below. Likewise, all providers named above, unless otherwise noted below, are authorized to release my medical record to Critical Connection, Inc. to accomplish that update.

Patient Signature: _____ Date:_____/_____/_____

(Parent or Legal Guardian)