BRIDGE
SAN ANTONIO
326 West Houston Street, San Antonio TX 78205
210-764-3700 Office | 210-764-3777 Fax

Patient Questionnaire

Please make sure to review any buttons or selections on this page that are in red and select what is appropriate.

Patient Name _____ DOB _____ Age _____
mm/dd/yyyy

Medical History – Please check if you or any blood relative has/had any of the following:

	You	Relative		You	Relative
Diabetes	☐	☐	Anemia	☐	☐
High/Low Blood Pressure	☐	☐	Alcoholism	☐	☐
Hepatitis/Liver Problems	☐	☐	Mental Illness	☐	☐
Heart Disease	☐	☐	Depression	☐	☐
Pulmonary Disease	☐	☐	HIV +	☐	☐
Kidney/Bladder Problems	☐	☐	AIDS	☐	☐
Arthritis	☐	☐	Blood Transfusions	☐	☐
Osteoporosis	☐	☐	Hearing Disorder	☐	☐
Heart Attack	☐	☐	Eye Disease	☐	☐
Stroke	☐	☐	Epilepsy/Convulsions	☐	☐
High Cholesterol	☐	☐	Recent Weight Loss/Gain	☐	☐
Stomach Ulcer	☐	☐	Migraine Headaches	☐	☐
Bowel Problems	☐	☐	Sinus/Throat Infections	☐	☐
Neurological	☐	☐	Angina/Chest Pains	☐	☐
Cancer (Type)	☐	☐	Any Other Disease (If yes, give details)	☐	☐

Any Unusual Family Illnesses ☐
(If yes, give details)

Are your immunizations current? Y N **Height** _____ **Weight** _____ **B/P** _____

Are you currently taking Medications?
(This includes prescription, non-prescription, vitamins and herbal preparations)

Medication	Dose	Times/Day	Medication	Dose	Times/Day

DRUG ALLERGIES

Drug	Reaction

Do You Now or Have You Ever Used:

Cigarettes? Y N _____ pk/day

Alcohol? Y N _____ glasses/week

Drugs of Abuse? Y N _____

Women: Is there any chance you may be pregnant? Y N

Surgery: Have You Ever Had Surgery? Y N (If yes, please give details)

Have you ever been advised to have any Surgical Procedure, which has not been done? Y N (if yes, explain)

Signature _____ **Date** _____
mm/dd/yyyy

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When entering phone numbers, social security number etc. below, please enter numbers only. Do not enter dashes or other symbols.

PATIENT REGISTRATION FORM

Today's Date: _____ ☐ **New Patient** ☐ **Updated Information**

Patient Legal Name: _____ **Age:** _____ **Date of Birth:** _____
Last First Middle mm/dd/yyyy

Address: _____ TX
Street or PO Box City State Zip Code

Hm. Phone # _____ **Mbl #** _____ **Other #** _____

Email: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow ☐ Other **Sex:** ☐ Male ☐ Female

Social Security # _____ **Driver's License #** _____ **State** _____

Employer/School: _____ **Occupation:** _____ **Work #** _____

Spouse/Parent's Name: _____ **Hm#** _____ **Wk#** _____

RESPONSIBLE PARTY: (If other than patient): Relationship to Patient: _____

Name **Address** **City** **State** **Zip code**

Home # **Work #** **Occupation**

LOCAL PERSON TO CONTACT IN CASE OF EMERGENCY:

Name: _____ **Relationship:** _____ **Phone #:** _____

Address: _____
Street or PO Box City State Zip Code

MEDICAL ARE: I authorize RCG Providers or designee to provide myself or my dependent with reasonable and proper medical care according to today's standards.

Signature of Patient or Guarantor: _____ **Date:** _____

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PATIENT INTAKE: MEDICAL FORM
(To be completed by patient)

Date: _____

Name: _____ DOB: _____ SS# _____

Address: _____ TX

Phone: (H) _____ (C) _____ Email: _____

Marital Status: _____ Occupation: _____ Employer: _____

Emergency Contact/Relationship/Phone#: _____

Primary Care Physician/Phone #: _____

Date of Last Physical: _____ Date of Last Menstrual Cycle: _____

Childhood History (where did you grow up, # brothers & sisters): _____

_____

Educational History: _____

Employment History: _____

Relationship/Marriage: _____

Children: _____

Current Living Arrangement: _____

Criminal Justice History: _____

Reproductive History (LMP, # of pregnancies): _____

CURRENT/PAST MEDICAL CONDITIONS

(Asthma, Hypertension, Liver/Thyroid/GI Disease, STDs, Cardiovascular, Seizure Disorder, Diabetes, Head Trauma, other)

CURRENT or PAST MEDICAL CONDITION	APPROXIMATE DATE OF ONSET OR DIAGNOSIS

PAST SURGERIES

(Gall Bladder removal, Appendectomy, Hysterectomy, Heart Surgery, Angioplasty, other)

PAST SURGERIES	APPROXIMATE DATE OF SURGERY

ALLERGIES

Medical/Environmental Allergies and Reaction: (Example rash, swelling, trouble breathing)

ALLERGIC TO	REACTION

MEDICATIONS

Please list any other medications you take that are not listed in the substance abuse patient questionnaire page (include any medications for Depression, Bipolar Disorder, Anxiety Disorder, Schizophrenia, ADD, ADHD or any other psychiatric illnesses).

MEDICATION NAME	DOSAGE/ FREQUENCY	PRESCRIBING PHYSICIAN	REASON TAKING MEDICATION

LIST PRIOR INPATIENT TREATMENT PROGRAMS INCLUDING OUTPATIENT TREATMENT PROGRAMS (IOP)

NAME OF PROGRAM	DATES	LENGTH

Please make sure to review any buttons or selections on this page that are in red and select what is appropriate.

What is your longest period of (clean and sober) sobriety? _____

What helped you remain sober? _____

Do you have a family history of addiction? Yes No
If yes, who:_____

Do you have any current legal problems? Yes No
If yes, please describe:_____

Are you currently in a Pain Management Program? Yes No
If yes: Name of Program/Phone #:_____

Are you currently under the care of a Psychiatrist, Psychologist, Therapist or Counselor? Yes No
If yes: Name/Phone #_____

Have you ever experienced, witnessed, or been confronted with traumatic events (abuse)? Yes No

Have you ever thought about, planned or attempted suicide? Yes No
If yes please explain (include dates): _____

Are you currently suicidal? Yes No
If yes please explain: _____

CURRENT SUBSTANCE USE HISTORY

	ROUTE	HOW OFTEN/ AMOUNT	LAST QUANITY USED	DATE/TIME LAST USE
ALCOHOL				
COCAINE				
CRYSTAL METH-AMPHETAMINES				
HEROIN				
LSD/HALLUCINOGENS				
METHADONE				
MARIJUANA				
OPIATES (Codeine, Morphine, Oxy, Hydrocodone, Dilaudid, Fentanyl)				
PCP				
STIMULANTS				
SLEEPING PILLS				
BENZODIAZEPINES (Xanax, Klonopin, Valium, Ativan, Librium, Restoril)				
KRATOM, K2, SPICE, BATH SALTS				
ECSTASY				
STEROIDS				

PAST SUBSTANCE USE HISTORY

	ROUTE	HOW OFTEN/ AMOUNT	LAST QUANITY USED	DATE/TIME LAST USE
ALCOHOL				
COCAINE				
CRYSTAL METH-AMPHETAMINES				
HEROIN				
LSD/HALLUCINOGENS				
METHADONE				
MARIJUANA				
OPIATES (Codeine, Morphine, Oxy, Hydrocodone, Dilaudid, Fentanyl)				
PCP				
STIMULANTS				
SLEEPING PILLS				
BENZODIAZEPINES (Xanax, Klonopin, Valium, Ativan, Librium, Restoril)				
KRATOM, K2, SPICE, BATH SALTS				
ECSTASY				
STEROIDS				

TOBACCO HISTORY

	HOW MUCH DAILY	HOW MANY YEARS	PAST/PRESENT
CIGARETTES			
SMOKELESS			
VAPE			

Ha. e you ever experienced any of the following when you attempted to stop drinking or using? Please check all that apply.

☐	Seizures	☐	Loss of Consciousness
☐	Tremors	☐	Hot/Cold Sweats
☐	Nausea and Vomiting	☐	Blackouts
☐	Hallucinations (DT's)	☐	Falls

The consequences of drug use change over time. Initially, there is a "honeymoon" period in which few, if any, of the costs have time to emerge. But, as drug use continues the consequences begin to accumulate. In what way has your perception of benefits become overwhelmed by consequences?

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Monday through Friday, 9am-4pm.

Before and after our scheduled office hours our answering service is available to answer your calls. The answering service cannot change nor cancel appointments. In the event your call is an emergency, please call 911 for assistance. Patients needing to reach the Physician or nurse during business hours for medication refills or general questions may leave a message on their voicemail. Messages are typically returned within 24 to 48 hours.

APPOINTMENTS – RCG is committed to providing continuous coverage and quality care to our patients. Please be prepared to provide updated demographic and insurance information when scheduling an appointment and medication count.

All patients must notify the office **210-764-3700** of any appointments/cancellations within **48 hours** of their scheduled appointment. Failure to notify the office will be charged a **full payment** assessed to your account. **(Office staff will give a courtesy call – but is not required). $25 for EARLY REFILLS before your schedule appointment.**

(TEXTING PHYICIANS FOR MEDICAL QUESTIONS OR CONCERNS WILL BE CHARGED $25 TEXT)

TRANSFER OF CARE – We are happy to forward your medical records to your new provider should you choose to seek care with another Physician.

FINANCIAL OBLIGATION: It is our office policy to collect payment from patients at the time services are rendered. This includes any outstanding payment that was required after hours services as stated in your financial contract with our clinic. We accept cash, and credit cards. **We do not accept Insurance or Medicare/Medicaid**. On your behalf as a courtesy, we will provide you with an Invoice to submit for your insurance company for you to file the claim.

FORMS/LETTERS/MEDICAL RECORDS – A minimum of **a $75.00 fee will be applied to the completion of forms or letters requested by our office.** Extra charge over 50 pages (**25¢**). **Payment is due when you collect the completed forms/letters.** FMLA paperwork or other forms require a 7-business day turnaround for completion**. (NO CHECKS)**

DRUG TESTING: IF YOU ARE SELECTED FOR A DRUG TEST YOU ARE REQUIRED TO COME IN THE SAME DAY! **NO SHOW IS A POSITIVE.**

Signature: _____ Date: _____