

Thomas P. McHugh M.D.  
800 Peakwood Drive, Suite 8C  
Houston, Texas 77090

Today's Date: \_\_\_\_\_

**THIS INFORMATION IS CONFIDENTIAL**

**PATIENT INFORMATION**

Patient Name: \_\_\_\_\_  
Last First Middle

Maiden Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SS # \_\_\_\_\_

Street Address: \_\_\_\_\_  
City State Zip

Phone Numbers: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Other: \_\_\_\_\_

E-mail address: \_\_\_\_\_

Marital Status (Circle one): Married Widowed Divorced Single Separated

Patient's Employer: \_\_\_\_\_

Address: \_\_\_\_\_

Spouse's Name (if applicable): \_\_\_\_\_ SS #: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_

Address: \_\_\_\_\_  
City State Zip

**CONTACTS**

Emergency Contact: \_\_\_\_\_

Phone: \_\_\_\_\_

Relation: \_\_\_\_\_

**List all the Reasons for which You Are Seeing the Doctor:**

\_\_\_\_\_  
\_\_\_\_\_

**How did you hear about Dr. McHugh?** \_\_\_\_\_

PATIENT HISTORY

Circle Any of the Following That Have Occurred in Your Family:

Arthritis Diabetes Strokes Cancer Other: \_\_\_\_\_
Birth Defects High Blood Pressure Tuberculosis Mental Illness

List previous surgeries including dates (be specific):

List any recent hospitalizations:

List any prescription or over-the-counter medications you are taking:

Circle if you use or have ever used: Alcohol Cigarettes Recreational Drugs

Circle all conditions which you now have or have ever had:

- Aids/HIV Epilepsy Neurological Problems
Anemia Goiter Parasitic Infection
Appendicitis Hay Fever Pneumonia
Arthritis Heart Attack Poor Sense of Smell
Asthma Hepatitis Rheumatic Fever
Bladder Infection Herpes Scarlet Fever
Bleeding Tendency High Blood Pressure Seizures
Blood Transfusions High Fever Thyroid Problems
Breast Soreness Hirsutism (excess hair growth) Tonsillitis
Breast Tenderness Kidney Disease Tuberculosis
Chronic Bronchitis Liver Problems Ulcers
Diabetes Measles (Regular/German)
Dizziness Migraine Headaches Cancer (specify): \_\_\_\_\_

Name any drugs to which you are allergic:

Serious illnesses or injuries which you have had:

There are times when I may want to take photographs before and/or after a procedure. These are a part of your medical records. No one will view these photos except you, the patient, and myself.

I consent to be photographed before, during and after the treatment. These photographs will be the property of THOMAS P. McHUGH, M.D. and may be published in scientific journals and/or shown for scientific reasons.

Yes No Signature Of Patient \_\_\_\_\_ Date: \_\_\_\_\_

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES RENDERED TO THE PATIENT. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR COLLECTION FEES IF THE REMAINING BALANCE IS PLACED WITH COLLECTIONS OR AN ATTORNEY.

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM.

SIGNED: \_\_\_\_\_ DATE: \_\_\_\_\_

AUTHORIZATION