**COMPLETE FAMILY HEALTH CARE, PC**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5577 Chalkville Road Board Certified - America Board of Family Practice

Birmingham, Alabama 35235 Member – American Academy of Family Physicians

Phone (205) 853-3533

Today’s Date: July 19, 2016

**PATIENT INFORMATION**

Name: **Click here to enter text.** Sex: **Choose an item.**

Address: **Click here to enter text.** Zip: **Click here to enter text.**

Birthday: **Click here to enter text.** SS#: **Click here to enter text.**

Home Phone: **Click here to enter text.** Work Phone: **Click here to enter text.**

Cell Phone: **Click here to enter text.** Email: **Click here to enter text.**

Occupation: **Click here to enter text.** Employer: **Click here to enter text.**

Employer Address: **Click here to enter text.**

**WHO’S INSURANCE YOU FALL UNDER**

Name: **Click here to enter text.**

Address: **Click here to enter text.**

Relationship to Patient: **Click here to enter text.** Home Phone: **Click here to enter text.**

Employer: **Click here to enter text.** Work Phone: **Click here to enter text.**

Employer Address: **Click here to enter text.**

**INSURANCE INFORMATION**

Primary Company: **Click here to enter text.** Policy#: **Click here to enter text.**

Subscriber: **Click here to enter text.** Group#: **Click here to enter text.**

Secondary Company: **Click here to enter text.** Policy#: **Click here to enter text.**

Subscriber: **Click here to enter text.** Group#: **Click here to enter text.**

**OTHER INFORMATION**

In case of emergency, please notify: **Click here to enter text.**

Address: **Click here to enter text.** Phone#: **Click here to enter text.**

Your pharmacy: **Click here to enter text.** Phone#: **Click here to enter text.**

How did you learn of our practice? **Choose an item.**

Consent of Treatment/Financial Agreement

I consent to treatment necessary or desirable to the care of the patient first mentioned above, including, but not restricted to, whatever drugs, medicine, performance of operations and conduct of laboratory, x-ray, or other studies that may be used by the attending doctor, his nurse, or qualified designate. I also acknowledge full responsibility for the payment of such services, and agree to pay for them at the time of service, or as otherwise agreed. I understand that the charges made for professional services may not be covered in full by insurance although insurance may be filed. I understand that the patient or the responsible party s solely responsible for the payment of all service. If the account becomes delinquent in payment, I agree to pay all collection, including reasonable attorney’s fee. I authorize Grayson Valley Family Practice to release information to insurance carriers (including Workman’s Compensation) concerning my illness or treatment and I hereby assign the physician all payments for medical services rendered to myself or my dependents if assignment applies.

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Signature of Patient / Parent or Agent

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

Date

**Patient’s Personal History**

Social History:

Birth Place: **Click here to enter text.** Religion: **Click here to enter text.**

Marital Status: **Choose an item.** Occupation: **Choose an item.**

Allergies: **Click here to enter text.**

Present Mediations: What prescribed medications do you take?

1. Medication: **Click here to enter text.** Doctor’s Name: **Click here to enter text.**

2. Medication: **Click here to enter text.** Doctor’s Name: **Click here to enter text.**

3. Medication: **Click here to enter text.** Doctor’s Name: **Click here to enter text.**

4. Medication: **Click here to enter text.** Doctor’s Name: **Click here to enter text.**

5. Medication **Click here to enter text.**: Doctor’s Name: **Click here to enter text.**

6. Medication: **Click here to enter text.** Doctor’s Name: **Click here to enter text.**

Other medications (vitamins, health food store products, herbs, or supplements).

1. **Click here to enter text.** 2. **Click here to enter text.**

3. **Click here to enter text.** 4. **Click here to enter text.**

5. **Click here to enter text.** 6. **Click here to enter text.**

Medical:

Please list any diseases or medical conditions you have ever had.

**Click here to enter text.**

Surgical:

Please list any surgeries you have had with the type of surgery and year it was done.

1. **Click here to enter text.** Year: **Click here to enter text.**

2. **Click here to enter text.** Year: **Click here to enter text.**

3. **Click here to enter text.** Year: **Click here to enter text.**

4. **Click here to enter text.** Year: **Click here to enter text.**

5. **Click here to enter text.** Year: **Click here to enter text.**

6. **Click here to enter text.** Year: **Click here to enter text.**

Personal Habits:

Do you use tobacco? **Choose an item.**

If yes, do you use:  Cigarettes  Pipe  Smokeless Tobacco  Electronic Cigarettes

Other: **Click here to enter text.** Age Started **Click here to enter text.**

Packs per day average: **Click here to enter text.**

Amount of caffeine drinks you drink a day? **Choose an item.**

Do you drink?:  Coffee  Caffeinated Beverages  Tea  Energy Drinks

Do you regularly drink alcohol?  Yes  No

If yes, do you drink:  Beer Wine Hard Liquor Wine Coolers

Immunizations:

Have you ever received?

Tetanus Shot?  Yes  No Date of last shot: **Click here to enter text.**

Flu Vaccine?  Yes  No Date of last shot: **Click here to enter text.**

Pneumonia Vaccine?  Yes  No Date of last shot: **Click here to enter text.**

OB/GYN: **(Female)**

Date of your last menstrual period? **Click here to enter a date.**

How many times have you been pregnant? **Click here to enter text.**

How many babies did you carry to full term? **Click here to enter text.** How many premature births? **Click here to enter text.**

How many miscarriages? **Click here to enter text.** How many children are still living? **Click here to enter text.**

If you are still having periods, are your cycles regular? **Choose an item.**

How many days apart are they? **Click here to enter text.** How many days of flow do you have? **Click here to enter text.**

Flow is? **Choose an item.** When was your last pap smear? Date: **Click here to enter text.**

When was your last mammogram? **Click here to enter a date.**

Do you practice breast self-examination? **Choose an item.**

Did you have high blood pressure during pregnancy? **Choose an item.**

Did you have diabetes (high blood sugar) during pregnancy? **Choose an item.**

Has any relative had breast cancer? **Choose an item.** Has any relative had ovarian cancer? **Choose an item.**

Have you had a hysterectomy?  Yes  No

Have you been through menopause?  Yes  No

Have you had any vaginal bleeding after menopause?  Yes  No

Family History:

Circle all family members who have or had one of the following diseases or conditions.

**M**=mother, **F**=father, **S**=sister, **B**=brother, **GM**=grandmother, **GF**=grandfather, **A**=aunt, **U**=uncle

**Anemia**:  M  F  S  B  GM  GF  A  U  Other **Click here to enter text.**

**Asthma**:  M  F  S  B  GM  GF  A  U  Other **Click here to enter text.**

**Bleeding Tendency**:  M  F  S  B  GM  GF  A  U  Other **Click here to enter text.**

**Cancer**:  M  F  S  B  GM  GF  A  U  Other **Click here to enter text.**

**Depression**:  M  F  S  B  GM  GF  A  U  Other **Click here to enter text.**

**Diabetes**:  M  F  S  B  GM  GF  A  U  Other **Click here to enter text.**

**Drug/Alcohol Problem**: M  F  S  B  GM  GF  A  U  Other **Click here to enter text.**

**Epilepsy**:  M  F  S  B  GM  GF  A  U  Other **Click here to enter text.**

**Glaucoma**:  M  F  S  B  GM  GF  A  U  Other **Click here to enter text.**

**Gout**:  M  F  S  B  GM  GF  A  U  Other **Click here to enter text.**

**Heart Disease**:  M  F  S  B  GM  GF  A  U  Other **Click here to enter text.**

**High Blood Pressure**:  M  F  S  B  GM  GF  A  U  Other **Click here to enter text.**

**High Cholesterol**:  M  F  S  B  GM  GF  A  U  Other **Click here to enter text.**

**Kidney Disease**: M  F  S  B  GM  GF  A  U  Other **Click here to enter text.**

**Leukemia**:  M  F  S  B  GM  GF  A  U  Other **Click here to enter text.**

**Mental Illness**: M  F  S  B  GM  GF  A  U  Other **Click here to enter text.**

**Migraine Headaches**:  M  F  S  B  GM  GF  A  U  Other **Click here to enter text.**

**Obesity**:  M  F  S  B  GM  GF  A  U  Other **Click here to enter text.**

**Stroke**:  M  F  S  B  GM  GF  A  U  Other **Click here to enter text.**

**Suicide**:  M  F  S  B  GM  GF  A  U  Other **Click here to enter text.**

**Thyroid Disease**: M F  S  B  GM  GF  A  U  Other **Click here to enter text.**

**Tuberculosis**:  M  F  S  B  GM  GF  A  U  Other **Click here to enter text.**

**Ulcer**:  M  F  S  B  GM  GF  A  U  Other **Click here to enter text.**

**Other**: **Click here to enter text.**

Review of Systems:

**Circle all symptoms or problems that you are currently having:**

**General:**  change in weight,  in appetite,  fatigue,  fevers,  chills,  night sweats,  trouble sleeping.

**Head and Neck:** headache,  change in vision,  decreased hearing,  ringing in the ears,  dizziness,  sinus problems,  nose bleeds,  nasal discharge,  sore throat,  runny nose,  dental problems,  problems chewing or swallowing,  choking on food,  hoarseness.

**Breasts:**  breast lumps,  breast tenderness,  discharge from the nipples,  lumps under the arms.

**Chest:**  cough,  production of phlegm,  coughing up blood,  wheezing,  shortness of breath on exertion,  shortness of breath at rest,  shortness of breath on climbing stairs,  frequent bronchitis.

**CVS:**  chest pain,  chest tightness,  chest heaviness,  chest pressure,  palpitations,  fainting,  light headedness,  swelling of the ankles,  trouble breathing when lying down,  leg cramps,  pain in calves upon walking,  cold feet,  blue feet,  varicose veins.

**GI:**  nausea,  vomiting,  vomiting blood,  vomiting coffee grounds,  heartburn,  belching,  bloating,  abdominal pain,  jaundice,  constipation,  diarrhea,  incomplete emptying,  change in bowel habit in the past 6 months,  rectal spotting or blood in stool.

**GU:**  pain or burning upon urination,  blood in the urine,  frequency of urination,  trouble starting to urinate,  sensation of incomplete emptying,  passing of urine when laughing,  sneezing,  coughing,  or carrying a heavy weight;  urgency or trouble holding urine,  do you ever get up at night to urinate,  dark colored urine.

**(Female) Gynecological:**  irregular periods,  painful menstrual cycle,  abnormal vaginal bleeding,  vaginal discharge,  pain with intercourse,  bleeding after intercourse.

**Endocrine:**  excessive urination,  excessive thirst,  skin or hair changes,  heat intolerance.

**Back and Extremities:**  back pain,  neck pain,  stiff or swollen joints,  painful joints,  muscle aches.

**Skin:**  rashes,  itching,  easy bruising,  skin tags.

**CNS:**  muscle weakness,  numbness and tingling or extremities,  seizures,  problems with walking,  memory loss,  lack of coordination,  problems with balance.

**Psych:**  anxiety,  panic attacks,  depression.

**PRIVACY PRACTICES**

**ACKNOWLEDGEMENT**

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I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

NAME: **Click here to enter text.** Date of Birth: **Click here to enter text.**

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_