**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.

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

 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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_