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

5577 Chalkville Road

Birmingham, Alabama 35235

Phone (205) 853-3533

Fax (205) 856-3808

Today’s Date: Click or tap here to enter text.

**PATIENT INFORMATION**

Name: Click or tap here to enter text. Gender: [ ] Male / [ ]  Female

Full Address: Click or tap here to enter text.

Date of Birth: Click or tap here to enter text. SS#: Click or tap here to enter text.

Home Phone: Click or tap here to enter text. Cell Phone: Click or tap here to enter text.

Email: Click or tap here to enter text.

Occupation: Click or tap here to enter text. Employer: Click or tap here to enter text.

Employer Address: Click or tap here to enter text.

**INSURANCE INFORMATION**

Name of Insurance: Click or tap here to enter text.

Contract / Member#: Click or tap here to enter text. Group#: Click or tap here to enter text.

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**PERSONAL HISTORY**

Birthplace: Click or tap here to enter text. Religion: Click or tap here to enter text.

Marital Status: [ ]  Married [ ]  Single [ ]  Divorced [ ]  Widowed

Occupation: [ ]  Retired [ ]  Disabled [ ]  Unemployed [ ]  Employed

**MEDICAL INFORMATION**

Pharmacy: Click or tap here to enter text.

List Allergies: Click or tap here to enter text.

Current Medications and Doctor that prescribed the medication:

Medication: Click or tap here to enter text. Prescriber: Click or tap here to enter text.

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Medication: Click or tap here to enter text. Prescriber: Click or tap here to enter text.

Medication: Click or tap here to enter text. Prescriber: Click or tap here to enter text.

List other medications (vitamins, herbs, supplements, health food store products) over the counter:

Click or tap here to enter text.

List any diseases or medical conditions you have ever had:

Click or tap here to enter text.

List any surgeries you have had with year they were performed:

Click or tap here to enter text. Year: enter

Click or tap here to enter text. Year: enter

Click or tap here to enter text. Year: enter

Click or tap here to enter text. Year: enter

Click or tap here to enter text. Year: enter

Click or tap here to enter text. Year: enter

**Immunizations**:

Tetanus Shot? [ ]  Yes [ ]  No Year: enter COVID 19 Vaccine? [ ]  Yes [ ]  No Year: enter

Flu Vaccine? [ ]  Yes [ ]  No Year: enter Pneumonia Vaccine? [ ]  Yes [ ]  No Year: enter

**PERSONAL HABITS**

Do you use tobacco products? [ ]  Yes [ ]  No Age Started: enter Age Stopped: enter

Choose all that apply: [ ]  Cigarettes [ ]  Pipe [ ]  Smokeless [ ]  E-Cigarette [ ]  Vape

Number/Packs or Cans per day? Click or tap here to enter text.

Approx. How many caffeine drinks do you consume a day? Click or tap here to enter text.

What type of caffeine drinks? [ ]  Coffee [ ]  Tea [ ]  Caffeinated Beverages [ ]  Energy Drinks

Do you consume alcohol? [ ]  No [ ]  Socially [ ]  Weekends Only [ ]  1-3 a week [ ]  4 or more a week [ ]  1 everyday [ ] 2 or more everyday

What type: [ ]  Beer [ ]  Wine [ ]  Hard Liquors [ ]  Wine Coolers

**OB/GYN: (Females)**

Date of last menstrual period? Click or tap here to enter text.

Date of last Pap smear? Click or tap here to enter text.

Number of times you have been pregnant? Choose an item. How many full-term carries? Choose an item.

How many premature births? Choose an item. How many miscarriages? Choose an item.

How many children are still living? Choose an item. If still having periods are your cycles regular? [ ]  Yes [ ]  No

How many days apart are they? Choose an item. How many days of flow do you have? Choose an item.

Are the flows [ ]  slight [ ]  moderate or [ ]  heavy? Date of last mammogram? Click or tap here to enter text.

Do you practice breast self-examinations? [ ]  Yes [ ]  No

Did you have high blood pressure during pregnancy? [ ]  Yes [ ]  No

Did you have diabetes (high blood sugar) during pregnancy? [ ]  Yes [ ]  No

Has any relative had breast cancer? [ ]  Yes [ ]  No

Has any relative had ovarian cancer? [ ]  Yes [ ]  No

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**:

Double click and highlight 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: enter text.

Asthma: M F S B GM GF A U Other: enter text.

Bleeding Tendency: M F S B GM GF A U Other: enter text.

Cancer: M F S B GM GF A U Other: enter text.

Depression: M F S B GM GF A U Other: enter text.

Diabetes: M F S B GM GF A U Other: enter text.

Drug or Alcohol Problem: M F S B GM GF A U Other: enter text.

Epilepsy: M F S B GM GF A U Other: enter text.

Glaucoma: M F S B GM GF A U Other: enter text.

Gout: M F S B GM GF A U Other: enter text.

Heart Disease: M F S B GM GF A U Other: enter text.

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

High Cholesterol: M F S B GM GF A U Other: enter text.

Kidney Disease: M F S B GM GF A U Other: enter text.

Leukemia: M F S B GM GF A U Other: enter text.

Mental Illness: M F S B GM GF A U Other: enter text.

Migraine Headaches: M F S B GM GF A U Other: enter text.

Obesity: M F S B GM GF A U Other: enter text.

Stroke: M F S B GM GF A U Other: enter text.

Suicide: M F S B GM GF A U Other: enter text.

Thyroid Disease: M F S B GM GF A U Other: enter text.

Tuberculosis: M F S B GM GF A U Other: enter text.

Ulcer: M F S B GM GF A U Other: enter text.

**Review of Systems**: Double click and highlight any that apply 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 claves 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.

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.

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 is 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 Complete Family Health Care to release/receive information to insurance carriers (including Workman’s Compensation), Alabama Public Health – ImmPRINT, pharmacy benefit managers and to other medical facility/personnel that I’m being referred to concerning my medical condition/s 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 E-MAIL AND TEXT MESSAGING**

Due to the changing world of healthcare and technology, Complete Family Health Care may have the ability to provide our patients with certain types of information via e-mail and/or text messaging. If you wish to have the opportunity to receive information of this type, please complete the form below. This will help us to keep you informed about our practice and your health.

Complete Family Health Care believes strongly in protecting the privacy of our patients. This information will only be used to communicate with you or other medical facilities that are participating in your care. To protect your privacy, no confidential or personal information will be sent via e-mail or text without your consent. Any personal information will either need to be sent via portal, mailed, or picked up at the office.

Please print all information neatly and legibly.

Name Click or tap here to enter text.

E-mail Click or tap here to enter text.

Cell Phone Click or tap here to enter text.

I hereby give Complete Family Health Care permission to send messages to me as means of communication as indicated by my information listed above and with any future numbers I may provide.

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Patient Signature Date

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

Office Personal Witness Signature

**RELEASE OF INFORMATION**

I, Click or tap here to enter text., authorize Complete Family Health Care to discuss or provide medical information to the following person(s). I also understand that the following recipient(s) of the information may re-disclose the information and it may no longer be protected by the HIPAA privacy law. I further understand that I may revoke this authorization in writing at any time.

Name: Click or tap here to enter text. Relationship: Click or tap here to enter text.

Address: Click or tap here to enter text. Phone: Click or tap here to enter text.

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Name: Click or tap here to enter text. Relationship: Click or tap here to enter text.

Address: Click or tap here to enter text. Phone: Click or tap here to enter text.

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

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Office Person) (Office Person)