

Whitesburg Family Medicine

4800 Whitesport Drive. Huntsville, AL. 35801. 256.327.0888 fax 256.327.0891
 Elisa J. Haley, MD David A. McMillion, MD Sunitha A. Ghanta, MD

Patient Health History

Name: _____ Date of Birth: _____ Age: _____ Today's Date: _____

Please circle the doctor your appointment is with: Dr. Haley Dr. McMillion Dr. Ghanta

Last Doctor: _____ Reason For Leaving: _____

Other Doctors (Specialists): _____

Current Symptoms: _____

Drug or Food Allergies (What happens to you?): _____

Past Medical History (Check or Write In)

- | | | |
|---|--|---|
| Allergies (Seasonal) <input type="checkbox"/> | Diabetes <input type="checkbox"/> | Seizure Disorder <input type="checkbox"/> |
| Alzheimer's Disease <input type="checkbox"/> | Enlarged Prostate <input type="checkbox"/> | Stomach Ulcers <input type="checkbox"/> |
| Anemia <input type="checkbox"/> | GERD (Reflux) <input type="checkbox"/> | Stroke <input type="checkbox"/> |
| Anxiety <input type="checkbox"/> | Gout <input type="checkbox"/> | Thyroid Disease <input type="checkbox"/> |
| Arthritis <input type="checkbox"/> | Heart Disease <input type="checkbox"/> | Ulcerative Colitis <input type="checkbox"/> |
| Asthma <input type="checkbox"/> | High Blood Pressure <input type="checkbox"/> | Venereal Disease (STD) <input type="checkbox"/> |
| Bleeding Disorder <input type="checkbox"/> | High Cholesterol <input type="checkbox"/> | Other <input type="checkbox"/> |
| Blood Clots <input type="checkbox"/> | HIV <input type="checkbox"/> | _____ |
| Breast Lump <input type="checkbox"/> | Liver Disease <input type="checkbox"/> | _____ |
| Cancer <input type="checkbox"/> | Migraines <input type="checkbox"/> | _____ |
| Chronic Bronchitis <input type="checkbox"/> | Multiple Sclerosis <input type="checkbox"/> | _____ |
| Congestive Heart Failure <input type="checkbox"/> | Osteoporosis <input type="checkbox"/> | _____ |
| COPD <input type="checkbox"/> | Parkinson's Disease <input type="checkbox"/> | _____ |
| Crohn's Disease <input type="checkbox"/> | Psychiatric Disease <input type="checkbox"/> | _____ |
| Depression <input type="checkbox"/> | Poor Circulation <input type="checkbox"/> | _____ |

Surgeries

Surgery	Date / Location	Surgeon
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medications

Name: (Name of drug)	4.	8.
Dose: (1 twice a day, etc)		
1.	5.	9.
2.	6.	10.
3.	7.	11.

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Patient Health History (Continued)

Name: _____

Today's Date: _____

Family History

In each box please write age of disease onset	Addiction	Anxiety	Arthritis	Bleeding Disorder	Cancer (Type)	Colitis	Dementia	Diabetes	Eye Disease	Heart Attack	Heart Disease	High Blood Pressure	High Cholesterol	Kidney Disease	Liver Disease	Lung Disease	Migraines	Osteoporosis	Psychiatric Disease	Stroke	Thyroid Disease	Other	
Mother																							
Father																							
Sister																							
Brother																							
Grandmother																							
Grandfather																							

OB / GYN

Age of first menstrual period _____
 Last menstrual period _____
 How long do your periods last? _____
 How heavy are they? _____
 Any pain with your periods? _____
 Associated with PMS or PMDD? _____
 Are your periods regular? _____
 Age of menopause _____
 Any bleeding since menopause? _____

Number of pregnancies _____
 Number of births <36 weeks _____
 Number of births >36 weeks _____
 Number of miscarriages _____
 Number of living children _____
 Other important information _____

Personal History

Marital Status _____
 How many children? _____
 Education _____
 Occupation _____
 Alcohol? Amount and type _____
 Do you smoke? _____
 How many packs a day? _____
 Did you ever smoke? _____
 When did you quit? _____
 When did you start? _____
 Do you use drugs? _____
 Have you ever used drugs? _____
 What kind? _____

Are you sexually active? _____
 With men, women or both _____
 Do you exercise? _____
 What kind of exercise and how often? _____

 How much caffeine per day? _____

 Toxic exposure? _____
 Hobbies _____

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Patient Health History (Continued)

Name: _____

Today's Date: _____

Symptoms (in the last 6 months)

<u>General</u>	<u>Cardiovascular</u>	<u>Gastrointestinal</u>	<u>Musculoskeletal</u>	<u>Genitourinary</u>
Fever <input type="checkbox"/>	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Poor appetite	<input type="checkbox"/> Joint pain	<input type="checkbox"/> Painful urination <input type="checkbox"/>
Chills <input type="checkbox"/>	<input type="checkbox"/> Chest tightness	<input type="checkbox"/> Swallowing problems	<input type="checkbox"/> Joint swelling	<input type="checkbox"/> Blood in urine <input type="checkbox"/>
Fatigue <input type="checkbox"/>	<input type="checkbox"/> Irregular beat	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Joint stiffness	<input type="checkbox"/> Can't hold urine <input type="checkbox"/>
Weight loss <input type="checkbox"/>	<input type="checkbox"/> Rapid heartbeat	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Joint deformity	<input type="checkbox"/> Can't urinate <input type="checkbox"/>
Skin changes <input type="checkbox"/>	<input type="checkbox"/> Ankle swelling	<input type="checkbox"/> Constipation	<input type="checkbox"/> Muscle pain	<input type="checkbox"/> Weak stream <input type="checkbox"/>
	<input type="checkbox"/> Varicose veins	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Weakness	<input type="checkbox"/> Going too often <input type="checkbox"/>
<u>EENT</u>	<input type="checkbox"/> Exercise intolerance	<input type="checkbox"/> Gas	<input type="checkbox"/> Muscle cramps	<input type="checkbox"/> Increased night time urination <input type="checkbox"/>
Hearing changes <input type="checkbox"/>		<input type="checkbox"/> Bloating	<u>Neurological</u>	<input type="checkbox"/> Discharge: Penile / Vaginal <input type="checkbox"/>
Vision changes <input type="checkbox"/>	<u>Pulmonary</u>	<input type="checkbox"/> Excessive thirst	<input type="checkbox"/> Weakness on one side <input type="checkbox"/>	<u>Psychiatric</u>
Double vision <input type="checkbox"/>	<input type="checkbox"/> Persistent cough	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Headache <input type="checkbox"/>	<input type="checkbox"/> Change in mood <input type="checkbox"/>
Ringling in ears <input type="checkbox"/>	<input type="checkbox"/> Wheeze	<input type="checkbox"/> Nausea	<input type="checkbox"/> Fainting <input type="checkbox"/>	<input type="checkbox"/> Loss of pleasure <input type="checkbox"/>
Dizziness <input type="checkbox"/>	<input type="checkbox"/> Blood in sputum	<input type="checkbox"/> Stomach pain	<input type="checkbox"/> Seizures <input type="checkbox"/>	<input type="checkbox"/> Can't sleep <input type="checkbox"/>
Eye pain <input type="checkbox"/>	<input type="checkbox"/> Short of breath	<input type="checkbox"/> Blood in stools	<input type="checkbox"/> Loss of balance <input type="checkbox"/>	<input type="checkbox"/> Too much energy <input type="checkbox"/>
Ear pain <input type="checkbox"/>	<input type="checkbox"/> Painful breathing	<input type="checkbox"/> Blood in vomit	<input type="checkbox"/> Tremor <input type="checkbox"/>	
Nose bleeds <input type="checkbox"/>	<input type="checkbox"/> TB exposure	<input type="checkbox"/> Change in stools		
Hoarseness <input type="checkbox"/>		<input type="checkbox"/> Tarry stools		

Health Maintenance/ Immunizations

	<u>When?</u>	<u>Result</u>
Aneurysm Screen:	_____	_____
Last Blood Work:	_____	_____
Last Stress Test:	_____	_____
Last Colonoscopy:	_____	_____
Last DEXA Scan:	_____	_____
Last Eye Exam:	_____	_____
HIV Screen:	_____	_____
Last Mammogram:	_____	_____
Last Pap Smear:	_____	_____

Last Flu Vaccine	_____
Last Pneumonia Vaccine	_____
Last Tetanus Vaccine	_____
Last Chicken Pox Vaccine	_____
Last HPV (Gardasil) Vac.	_____
Last Shingles Vaccine	_____

Reviewed By: _____

Date: _____

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Patient Registration

Name: _____	Referred Here By: _____
Address: _____	City: _____ State: _____ Zip: _____
Home Phone: _____	Cell: _____ Sex: _____ DOB: _____
Preferred Language: _____	Race: _____ Ethnicity: _____
Age: _____	SSN: _____ Drivers Lic. #: _____ Marital Status: _____
Employer: _____	Occupation: _____ Work Phone: _____
Employer Address: _____	Date of Employment: _____
Spouses Name: _____	Spouses Employer: _____
Spouses Occupation: _____	Spouses Work Phone: _____
Emergency Contact: _____	Relation: _____ Phone: _____
PRIMARY INSURANCE INFORMATION	
Name: _____	
Group# _____	Contract#: _____ Co-pay _____
Name of Insured: _____	Relation to Patient: _____
Sex: _____	DOB: _____ SSN: _____
SECONDARY INSURANCE INFORMATION	
Name: _____	
Group# _____	Contract#: _____ Co-pay _____
Name of Insured: _____	Relation to Patient: _____
Sex: _____	DOB: _____ SSN: _____

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original. I hereby authorize Whitesburg Family Medicine to apply benefits on my behalf for the covered services rendered by the office, or by the office's order. I request that payment from my insurance company be made directly to the party who accepts assignment. I certify that the information I have reported with regard to the patient's insurance coverage is correct.

I hereby acknowledge that I accept legal responsibility for all changes in connection with medical care provided by Whitesburg Family Medicine to myself, my minor child or as guardian of the above patient. I understand that my insurance company may not reimburse all of my charges incurred and I am responsible for all charges not satisfied in full by my insurance except where liability is limited by contract or State / Federal law. I will also be responsible for the cost of collection fees should my account be turned over to a collection agency.

Signed _____ Date: _____

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Receipt of Privacy Practices; Consent for Use / Disclosure of Protected Health Information (PHI)

I, _____, was provided a copy of Whitesburg Family Medicine's Privacy Practices Notification. Whitesburg Family Medicine may revise its notification at any time. I understand that a copy is always available at my request. By signing this document I acknowledge that I have read, understand and agree to the terms of this consent. Further, I hereby consent and authorize Whitesburg Family Medicine to use or disclose my PHI in conjunction with Whitesburg Family Medicine's treatment, payment or healthcare operations in accordance with the terms of this consent.

Signature of Patient / Guardian

Date

Further I hereby authorize and give my consent to Whitesburg Family Medicine to leave messages on my answering machine / voicemail for the following (check all that apply)

Appointment Reminders	_____	Prescription Refills	_____
Medical Information	_____	Test Results	_____
Insurance / Payment Issues	_____	Mail	_____

I further authorize and give consent to Whitesburg Family Medicine to communicate any of my PHI to the following person / persons:

Name	Relationship

Signature of Patient / Guardian

Date

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Authorization for Release / Request of Protected Health Information

Patient's Name: _____ DOB: _____

Address: _____

City: _____ State: _____ ZIP: _____

SSN#: _____ Patient's Phone #: _____

Date of Request: _____ Date Information Needed: _____

I Authorize David A. McMillion
 Elisa J. Haley
 Sunitha A. Ghanta

I Authorize David A. McMillion
 Elisa J. Haley
 Sunitha A. Ghanta

OR

To RELEASE information to:

Name of Provider or Facility

Address

City, State, ZIP

Phone and Fax #

To RECEIVE information from:

Name of Provider or Facility

Address

City, State, ZIP

Phone and Fax

Reason for this request:

Healthcare Insurance Personal Other

Type of Records Requested:

Consult Lab Results Imaging Results
 Discharge Summary Office Notes Other
 History and Physical Operative Report

Medical Records Related to a Specific Illness or Injury and Date _____

All Medical Records

- I understand that my right to healthcare treatment is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a written request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a healthcare or medical insurance provider covered by privacy regulations, the information stated above could be re-disclosed.
- Release of HIV related information, mental health related care, or substance abuse diagnosis and treatment information requires additional authorization.
- There may be a charge for requested records.

Signature of Patient or Guardian

Date