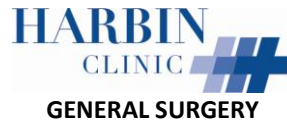


- ☐ Paul Brock, MD      ☐ Clarence Mckemie, MD  
☐ James Riley, MD    ☐ Ryland Scott, MD  
☐ Kelly Mayfield, MD



## Patient Information Form

Name \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Date \_\_\_\_\_  
 Family Physician \_\_\_\_\_ Referring Physician \_\_\_\_\_

### Present Illness

What is the reason for your visit today? \_\_\_\_\_ When did this begin? \_\_\_\_\_  
 What symptoms are you having? \_\_\_\_\_  
 What tests have you had? \_\_\_\_\_  
 What treatments have you tried? \_\_\_\_\_

### Past Medical History (Self) Please check any that apply and explain

- |   |  |
|---|--|
| <input type="checkbox"/> Bleeding Disorder _____        | <input type="checkbox"/> Hepatitis _____           |
| <input type="checkbox"/> Cancer _____                   | <input type="checkbox"/> High Cholesterol _____    |
| <input type="checkbox"/> Diabetes _____                 | <input type="checkbox"/> Kidney Disease _____      |
| <input type="checkbox"/> Heart Disease _____            | <input type="checkbox"/> Latex Allergy _____       |
| <input type="checkbox"/> High Blood Pressure _____      | <input type="checkbox"/> Leg Swelling _____        |
| <input type="checkbox"/> Lung Disease _____             | <input type="checkbox"/> Liver Disease _____       |
| <input type="checkbox"/> Abnormal Heart Rhythm _____    | <input type="checkbox"/> Other _____               |
| <input type="checkbox"/> Anemia _____                   | <input type="checkbox"/> Psychiatric Illness _____ |
| <input type="checkbox"/> Congestive Heart Failure _____ | <input type="checkbox"/> Seizures/Epilepsy _____   |
| <input type="checkbox"/> Deep Vein Thrombosis _____     | <input type="checkbox"/> Sleep Apnea _____         |
| <input type="checkbox"/> GERD/Reflux _____              | <input type="checkbox"/> Stomach Ulcer _____       |
| <input type="checkbox"/> Gastrointestinal Disease _____ | <input type="checkbox"/> Stroke _____              |
| <input type="checkbox"/> Heart Attack (MI) _____        | <input type="checkbox"/> Thyroid Problems _____    |

**Last Mammogram** Date: \_\_\_\_\_ ☐ Normal ☐ Abnormal (why?) \_\_\_\_\_  
**Last Colonoscopy** Date: \_\_\_\_\_ ☐ Normal ☐ Abnormal (why?) \_\_\_\_\_

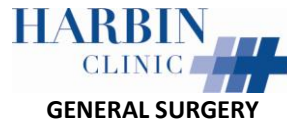
### Past Surgical History

Procedure	Date	Notes

### Current Medications

Medication	Dosage and How Often	Reason

- ☐ Paul Brock, MD    ☐ Clarence Mckemie, MD  
☐ James Riley, MD    ☐ Ryland Scott, MD  
☐ Kelly Mayfield, MD



**Pharmacy** \_\_\_\_\_ **Allergies** \_\_\_\_\_  
 Location \_\_\_\_\_

**Family History (Immediate Family)**

	Mother	Father	Brother	Sister	Other
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____

**Social History**

Marital Status    ☐ Married    ☐ Single    ☐ Divorced    ☐ Separated    ☐ Widowed    ☐ Domestic Partner  
 Tobacco Use    ☐ Never    ☐ Former    ☐ Current    \_\_\_\_ Pack(s) a Day for \_\_\_\_ Years From Age \_\_\_\_ to \_\_\_\_  
 Alcohol Use    ☐ No    ☐ Yes  
 If Yes:    Male- Do you consume more than 4 drinks/day & more than 14 drinks/week    ☐ No    ☐ Yes  
               Female- Do you consume more than 3 drinks/day & more than 7 drinks/week    ☐ No    ☐ Yes  
 Illegal Drug Use    ☐ Never    ☐ Yes    Type \_\_\_\_\_  
 Occupation \_\_\_\_\_ Highest education level obtained \_\_\_\_\_  
 Is a Blood Transfusion Acceptable in an Emergency?    ☐ No    ☐ Yes

**Review of Systems (Do You CURRENTLY have a problem with any of the following?)**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Weight gain/loss ____ # | <input type="checkbox"/> Change in Stool        | <input type="checkbox"/> Weakness          |
| <input type="checkbox"/> Fever                   | <input type="checkbox"/> Blood in Stool         | <input type="checkbox"/> Nosebleeds        |
| <input type="checkbox"/> Numbness/ Tingling      | <input type="checkbox"/> Indigestion/ Heartburn | <input type="checkbox"/> Sinus Problems    |
| <input type="checkbox"/> Trouble Walking         | <input type="checkbox"/> Shortness of Breath    | <input type="checkbox"/> Urinary Problems  |
| <input type="checkbox"/> Lethargy                | <input type="checkbox"/> Chest Pain             | <input type="checkbox"/> Kidney Stones     |
| <input type="checkbox"/> Nausea                  | <input type="checkbox"/> Palpitations           | <input type="checkbox"/> Wheezing          |
| <input type="checkbox"/> Vomiting                | <input type="checkbox"/> Swelling               | <input type="checkbox"/> Slow Healing      |
| <input type="checkbox"/> Difficulty Swallowing   | <input type="checkbox"/> Skin Changes           | <input type="checkbox"/> Bleeding Disorder |
| <input type="checkbox"/> Constipation            | <input type="checkbox"/> Joint Pain             | <input type="checkbox"/> Immunodeficiency  |
| <input type="checkbox"/> Bloating                | <input type="checkbox"/> Muscle cramps/ pain    | <input type="checkbox"/> Breast Symptoms   |

**Additional Information** Is there anything else, not already addressed, that we should know about you in order to provide more complete medical care?

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\_\_\_\_\_  
 Patient Signature/ Date

\_\_\_\_\_  
 Physician Signature/ Date

Nurse Use Only	
Ht: _____	Notes: _____
Wt: _____	_____
BP: ____ / ____	_____
P: _____	_____
R: _____	_____
T: _____	_____