MARSHALL FAMILY MEDICINE

Jessica Sparks, MD
Abigail Whitehead, CRNP

Social Security Number: _____ - _____ - _____

Patient Name: _____ _____ - _____ - _____ _____

Last First Middle Initial Date of Birth Age

Mailing Address: _____ City: _____ Zip: _____

Street Address: _____ City: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Patient Employer: _____ Patient Occupation_____

□ Male □ Female Race: _____ □ Non Hispanic □ Hispanic Language: _____

Email Address: _____

Pharmacy: _____ City: _____

- SPOUSE'S INFORMATION:

Name: _____ Social Security Number: _____ - _____ - _____

Mailing Address: _____ City: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Date of Birth: _____ - _____ - _____ Employer: _____

- RESPONSIBLE PARTY (IF SOMEONE OTHER THAN PATIENT) Relation to Patient: _____

Name: _____ Social Security Number: _____ - _____ - _____

Mailing Address: _____ City: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Date of Birth: _____ - _____ - _____ Employer: _____

- EMERGENCY CONTACT PERSON: (***Must have phone number different than patient***)

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Date of Birth: _____

Referred by: _____ Previous Primary Care Physician: _____

Reason for today's visit:

_____

ALLERGIES

Check all that apply:

___ Bactrim / Septra / Sulfa
___ Cephalosporin (i.e. Ceftin, Cefzil, Keflex)
___ Codienes (i.e. Prescription Cough Syrup)
___ Codones (i.e. Norco, Lortab, Percocet)
___ Insulin
___ Iodine / Shellfish
___ Foods _____

___ Latex
___ Penicillin
___ Tape/Adhesive
___ Pollens/Dust/Molds_____
___ Other _____
___ Other _____
___ Other _____

PAST MEDICAL HISTORY

Check all that apply:

CONDITION	DO YOU SEE A SPECIALIST FOR THIS Y/N	PHYSICIAN / OFFICE	CONDITION	DO YOU SEE A SPECIALIST FOR THIS Y/N	PHYSICIAN / OFFICE
___ Abnormal Menses	____	_____	___ Hepatitis (A, B or C)	____	_____
___ Anemia	____	_____	___ High Blood Pressure	____	_____
___ Anxiety	____	_____	___ High Cholesterol/Trig	____	_____
___ Arthritis (unspecified)	____	_____	___ Hyperthyroidism	____	_____
___ Asthma	____	_____	___ Hypothyroidism	____	_____
___ Breast Cancer	____	_____	___ Kidney Disease	____	_____
___ Cervical Cancer	____	_____	___ Kidney Stones	____	_____
___ Chronic Acid Reflux (GERD)	____	_____	___ Liver Disease	____	_____
___ Colon Cancer	____	_____	___ Lung Cancer	____	_____
___ COPD	____	_____	___ Polyps (Colon)	____	_____
___ Coronary Artery Disease	____	_____	___ Prostate Cancer	____	_____
___ Deep Vein Thrombosis	____	_____	___ Rheumatoid Arthritis	____	_____
___ Depression	____	_____	___ Seasonal Allergies	____	_____
___ Diabetes Type 1	____	_____	___ Stroke	____	_____
___ Diabetes Type 2	____	_____	___ Autoimmune Disease	____	_____
___ Emphysema	____	_____	___ Other _____		_____
___ Endometriosis	____	_____	___ Other _____		_____
___ Fibromyalgia	____	_____	___ Other _____		_____

Please list any medical issues not listed that you want us to be aware of:_____

_____

FAMILY HISTORY

If known, please list age of diagnosis in relation to breast cancer, colon cancer, and coronary artery disease diagnoses.

	Mother's Side			Father's Side			Siblings/Other		
	Mother	Grandmother	Grandfather	Father	Grandmother	Grandfather	Brother	Sister	Other
Breast Cancer	_____	_____	_____	_____	_____	_____	_____	_____	_____
Colon Cancer	_____	_____	_____	_____	_____	_____	_____	_____	_____
Coronary Artery Disease	_____	_____	_____	_____	_____	_____	_____	_____	_____
Cystic Fibrosis	_____	_____	_____	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____	_____	_____	_____
Gout	_____	_____	_____	_____	_____	_____	_____	_____	_____
High Cholesterol	_____	_____	_____	_____	_____	_____	_____	_____	_____
Huntington's Disease	_____	_____	_____	_____	_____	_____	_____	_____	_____
Hypertension	_____	_____	_____	_____	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____	_____	_____	_____	_____
Liver Disease	_____	_____	_____	_____	_____	_____	_____	_____	_____
Lung Cancer	_____	_____	_____	_____	_____	_____	_____	_____	_____
Muscular Dystrophy	_____	_____	_____	_____	_____	_____	_____	_____	_____
Osteoarthritis	_____	_____	_____	_____	_____	_____	_____	_____	_____
Osteoporosis	_____	_____	_____	_____	_____	_____	_____	_____	_____
Prostate Cancer	_____	_____	_____	_____	_____	_____	_____	_____	_____
Rheumatoid Arthritis	_____	_____	_____	_____	_____	_____	_____	_____	_____
Sickle Cell Anemia	_____	_____	_____	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____	_____	_____	_____
Other _____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Other _____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Other _____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Other _____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Other _____	_____	_____	_____	_____	_____	_____	_____	_____	_____

SURGICAL HISTORY

Surgery / Procedure	Approximate Date	Physician / Facility
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

FEMALE OBSTETRIC / GYNECOLOGICAL HISTORY

Do you have a Gynecologist? (Y / N) _____ Who? _____

When was your last pap smear? _____ Results: (Normal/Abnormal)

When was your last mammogram? _____ Results: (Normal/Abnormal)

Have you ever been pregnant? (Y / N) _____ How many times? _____

How many children have you given birth to? _____

Have you ever had a miscarriage? (Y/N) _____

DIAGNOSTIC IMAGING

Have you ever had any of the following diagnostic procedures?

Procedure	Y / N	Date Performed	Results	Provider / Office
Colonoscopy	_____	_____	_____	_____
Bone Density Study	_____	_____	_____	_____
Echocardiogram	_____	_____	_____	_____
MRI	_____	_____	_____	_____
CT	_____	_____	_____	_____
Ultrasound	_____	_____	_____	_____
Stress Test	_____	_____	_____	_____

If you are Diabetic, when was your last **Provider / Office**

Foot Exam _____ _____

Eye Exam _____ _____

IMMUNIZATIONS

Children / Adults under 24, are you current on all "school" vaccinations? _____

If no, what vaccines are outstanding? _____

Are you interested in the HPV Vaccine (Gardisil)? _____

Have you received a COVID vaccine, if so, please give manufacturer and number of doses/boosters:

_____

Adults over 24, when was your last

DATE

_____ TDaP (Tetanus, Diptheria and Pertussis)

_____ Pneumonia Vaccine

_____ Flu Vaccine

_____ Shingles Vaccine

SOCIAL HISTORY

Have you ever smoked or used tobacco products (Y / N) _____

Do you currently smoke or use tobacco products (Y / N) _____

What kind? _____

When was the last time you smoked or used tobacco products? _____

Do you drink alcohol (Y / N) _____

How often? Occasionally _____ Several drinks per week _____ 1-2 drinks/day _____ >2 drinks/day _____

CURRENT MEDICATIONS: Please list ALL medications you are currently taking. Please include all prescription and over the counter medications.

☐ **CHECK HERE IF YOU TAKE NO PRESCRIPTION OR OVER THE COUNTER MEDICATIONS.**

MEDICATION NAME	STRENGTH	HOW OFTEN?	REASON FOR TAKING

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of Marshall Family Medicine's Notice of Privacy Practices. By signing below I am only giving acknowledgement that I have received or have had the opportunity to receive the Notice of Privacy Practices.

_____

Patient Name (Printed)

Signature: _____ Date: _____

RELEASE OF INFORMATION AUTHORIZATION:

Due to federal privacy guidelines (HIPPA), Marshall Family Medicine is not allowed to divulge information to anyone other than the patient (or guardian of the patient) unless explicit written authorization is given to discuss personal medical information with someone other than you.

I, _____, give Family Medicine permission to release / discuss personal medical information to include the pickup of prescriptions and / or financial information to:

Name: _____Relationship to Patient: _____

Name: _____Relationship to Patient: _____

Signature: _____ Date: _____

GUARANTEE OF ACCOUNT: MUST BE 19 YEARS OF AGE TO SIGN

I, the undersigned, directly assign to Marshall Family Medicine all surgical and / or medical benefits, if any, otherwise payable to me for services rendered.

In consideration of services rendered or to be rendered, the undersigned agrees to pay all costs of collection and / or reasonable attorney fees, should the account be turned over to enforce collections of said charges. The undersigned hereby waivers all claims or rights of exemption allowed by the constitution of the state of Alabama or any other state of the United States.

I hereby authorize Marshall Family Medicine to release any information necessary to secure payment of benefits to my account.

Signature: _____ Date: _____

May we leave voicemails on the numbers you've provided? □ Yes □ No

Comments: _____