



Faith Family Medical Clinic

Name: _____ Date of Birth: _____ Age: _____ Gender: _____

Social Security #: _____ - _____ - _____ Email Address (for portal access): _____

Preferred Pharmacy: _____ Phone number : _____

Current Doctor _____ Are you here make Robert Callery as your Primary Care Provider? Yes No

Past Medical History

- | | | |
|--|--|---|
| <input type="checkbox"/> Diabetes (Type 1 or 2)-Onset date _____ | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> GERD (Acid Reflux) |
| <input type="checkbox"/> High blood pressure-Onset date _____ | <input type="checkbox"/> COPD-Onset Date _____ | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> High cholesterol-Onset date _____ | <input type="checkbox"/> Pulmonary embolism | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Thyroid problems-Onset date _____ | <input type="checkbox"/> Asthma-Onset date _____ | <input type="checkbox"/> Sleep Apnea--Cpap use? _____ |
| <input type="checkbox"/> Cancer (type and year) _____ | <input type="checkbox"/> Neuropathy | <input type="checkbox"/> Hepatitis/ HIV/ AIDS |
| <input type="checkbox"/> Blood-thinners--Since When _____ | <input type="checkbox"/> Stroke-What year _____ | <input type="checkbox"/> Anxiety/Depression |
| <input type="checkbox"/> Heart Attack or Stents-What year _____ | <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Skin Conditions |
| <input type="checkbox"/> Angina (chest pain) | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Obese or Overweight |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Vitamin B12 or D Deficiency |

Medication Allergies: _____

Other Medical Conditions: _____

Assistive devices used if any (circle) Cane Walker Wheelchair Brace Home health used currently? YES or NO

Previous Surgeries (Condition & date):

Hospitalizations (Reasons & Date):

Cardiology: Name _____

Pulmonology: Name _____

Endocrinology: Name _____

Rheumatology: Name _____

OB/GYN: Name _____

Hematology: Name _____

Neurology: Name _____

Urology: Name _____

Gastroenterology: Name _____

Orthopedic: Name _____

CONTINUE ON BACK----->

Please list the last date of the following:

- | | |
|---|--|
| <input type="checkbox"/> Colonoscopy: Date _____ | <input type="checkbox"/> Pneumonia (Pnuemovax): Date _____ |
| <input type="checkbox"/> Pap-Smear/Pelvic: Date _____ | <input type="checkbox"/> Pneumonia (Pprevnar): Date _____ |
| <input type="checkbox"/> Mammogram: Date _____ | <input type="checkbox"/> Shingles (Zostavax): Date _____ |
| <input type="checkbox"/> Dexa-Scan (Bone-density): Date _____ | <input type="checkbox"/> Shingles (Shingrix): Date _____ |
| <input type="checkbox"/> Tetanus: Date _____ | <input type="checkbox"/> Influenza: Date _____ |

Do you have an Advanced Directive? YES or NO
 ex. Living will or power of attorney

Last eye exam: _____
 By what provider? _____

Social History

Do you smoke? Yes No If yes, how long? _____ How many Pack per day _____
 Have you ever smoked Yes No If yes, how long? _____ How many Pack per day _____
 Do you Drink? Yes No

If yes, how often? Daily Weekends Occasionally Socially

What type of alcohol do you consume? Beer Wine Liquor

Do you use illicit drugs of any type? Yes No If yes, what type? _____

Do you exercise? Yes No If yes, how often? _____ What type? _____

Do you consume caffeine? Yes No If yes, How often _____ What type? _____

Have you fallen in the last year? Yes No

Family History

	Mother	Father	Sister	Brother	Children
Deceased					
Psych/Mental Health					
Cancer					
Diabetes					
Heart Disease					
High Blood Pressure					
Liver Disease					
Lung Disease					
Kidney Disease					
Seizures					
Stroke					



**Faith Family
Medical Clinic**

Authorization for Release of Protected Health Information Form

Patient Name: _____ Date of Birth: _____

I authorize this Facility to use or disclose my health information as described below.

1. **Type of information:** the entire health record as requested below
2. **Recipient of information:** The information identified above may be used by, or disclosed to Faith Family Medical Clinic.

1. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and HIPAA may no longer protect the information.
2. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to a licensed Facility staff member. I understand that the revocation will not apply to information that has already been released in response to this authorization.
3. Unless I specify differently on the line below, this authorization will expire until further notice: _____
4. I understand that the Facility will not condition the provision of treatment or payment on the provision of this authorization.

SIGNATURE of Patient or Guardian

Date

FOR OFFICE USE ONLY

Please send the following documents on the listed patient above:

- Last 2 Progress Notes or Office Visits
- Imaging Reports
- Last Comprehensive Lab Report
- Other Diagnostic Testing
- Other: _____

**511 E. Main Street
Brownsville, Tennessee 38012
Telephone: 731-734-2023 Fax: 877-753-3133**