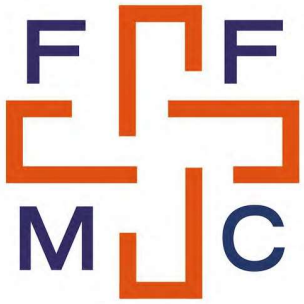


Faith Family Medical Clinic

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

- ❑ **Diabetes** (Type 1 or 2)-Onset date_____
- ❑ **High blood pressure**-Onset date_____
- ❑ **High cholesterol**-Onset date_____
- ❑ **Thyroid problems**-Onset date_____
- ❑ **Cancer** (type and year) _____
- ❑ **Blood-thinners**--Since When_____
- ❑ **Heart Attack or Stents**-What year_____
- ❑ **Angina (chest pain)**
- ❑ **Heart disease**
- ❑ **Heart murmur**
- ❑ **COPD**-Onset Date_____
- ❑ **Pulmonary embolism**
- ❑ **Asthma**-Onset date_____
- ❑ **Neuropathy**
- ❑ **Stroke**-What year_____
- ❑ **Blood Clots**
- ❑ **Cataracts**
- ❑ **Kidney disease**
- ❑ **GERD (Acid Reflux)**
- ❑ **Arthritis**
- ❑ **Anemia**
- ❑ **Sleep Apnea**--Cpap use?_____
- ❑ **Hepatitis/ HIV/ AIDS**
- ❑ **Anxiety/Depression**
- ❑ **Skin Conditions**
- ❑ **Obese or Overweight**
- ❑ **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:

❑ Colonoscopy: Date_____

❑ Pap-Smear/Pelvic: Date_____

❑ Mammogram: Date_____

❑ Dexa-Scan (Bone-density): Date_____

❑ Tetanus: Date_____

❑ Pneumonia (Pnuemovax): Date_____

❑ Pneumonia (Prevnar): Date _____

❑ Shingles (Zostavax): Date_____

❑ Shingles (Shingrix): Date_____

❑ Influenza: Date_____

Last eye exam:_____

By what provider?_____

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

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? _____

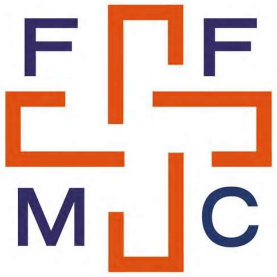
Do you exercise? ❑ Yes ❑ No If yes, how often? _____ What type? _____

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 heath 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 ifI 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

PLEASE SEE FAX COVER SHEET FOR SPECIFIC RECORDS BEING REQUESTED BY OUR OFFICE

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