Medical History

*****Please provide your nurse with this medical history form when called back for your evaluation.*****

Terry Westmoreland, M.D.
Misty Sharp, M.D.
Paula Atkins, FNP-BC
Celia Kidder, FNP-C

Patient Name_____

Date of Birth _____

Today's Date _____

NEW PATIENT – YES OR NO (PLEASE CIRCLE)

What is the primary reason for your visit today?_____

Primary Care Physician_____

Did a Physician's office schedule this appointment for you or refer you to this office? YES NO

If yes, Physician's Name_____

FEMALE PATIENTS ONLY: Are you currently pregnant or could be pregnant? YES NO
Are you currently breastfeeding? YES NO

CURRENT MEDICATIONS *(Please list, including over the counter medicines, vitamins & herbs)*

1._____ 9._____

2._____ 10._____

3._____ 11._____

4._____ 12._____

5._____ 13._____

6._____ 14._____

7._____ 15._____

8._____ 16._____

Pharmacy_____

DRUG ALLERGIES
Name of Drug & type of reaction

1._____

2._____

3._____

4._____

5._____

PAST SURGERIES
Surgery When?

1._____

2._____

3._____

4._____

5._____

PAST MEDICAL HISTORY *PLEASE CHECK THE PROBLEMS YOU HAVE HAD*

_____Allergies (seasonal)
_____Anemia
_____Arthritis
_____Artificial Heart Valve
_____Artificial Joints
_____Asthma
_____Bleeding / Blood Disorder
_____Cancer Type ? _____
_____Congestive Heart Failure
_____COPD / Emphysema
_____Depression
_____Diabetes
_____Drug Abuse /Addiction
_____Eczema
_____Fever Blisters
_____Gallbladder Disease
_____Gastrointestinal Disease
_____Glaucoma
_____Gout
_____Hearing / Vision Impairment
_____Heart Attack / Stents
_____Heart Murmur
_____Heart Surgery / Disease
_____Hepatitis
_____High Blood Pressure
_____High Cholesterol
_____HIV/AIDS
_____Joint Surgery
_____Keloids
_____Kidney Problems / Stones
_____Lupus/Auto-immune Disease
_____Menstrual Dysfunction
_____Migraine Headaches
___ Mitral Valve Prolapse
_____Mitral Valve Prolapse
_____Osteoporosis
_____PCOS
_____Prostate Problems
_____Psoriasis
_____Rosacea
_____Seizure Disorder
_____Stroke
_____ Thyroid Disease
___Vascular Disease

Do you have a pacemaker? YES NO If so when? _____

Do you have any disease, condition or problem not listed? If so, please describe:

_____

Do you have a history of skin cancer? YES NO

If so, what type and location (*example:. Squamous on the neck*) _____

How and where was it treated? _____

Do you smoke? YES NO Former Smoker? What year did you quit? _____
If you marked yes, are you interested in information about quitting? YES NO

Do you use alcohol? YES NO If yes, how often? Daily, Weekly, Monthly

Did you receive the flu vaccine between October1 – March 31? YES NO

If you are over the age of 65, have you had the pneumonia vaccine? YES NO

Do you have a: ___Living Will ___Advanced Care Plan

FAMILY HISTORY (*Please circle*)
Is there a family history of skin cancer? YES NO Type_____
Is there a family history of melanoma? YES NO Type_____
Is there a family history of any skin disorder? ___Psoriasis ___Eczema ___Lupus ___Acne
Is there a family history of? ___Cancer ___Diabetes ____High blood pressure ___Heart disease

If I have a change of health, I will inform my physician of this at my next appointment.

_____ ____/____/____
Signature of Patient Date
(Parent or Guardian if Child or Minor)

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OFFICE USE ONLY

(Not necessary for patient to fill out)

Height_____ Weight_____ BP_____ Pulse _____

Medical Information Release Form

(HIPAA Release Form)

Name: _____ Date of Birth: ___/___/___

Release of Information

[ ] I authorize the release of information including the diagnosis, records, examinations rendered to me and claims information. This information may be released to:

*** PLEASE FILL IN BLANKS WITH NAMES ***

[ ] Spouse: _____

[ ] Child(ren): _____

[ ] Other: _____

[ ] Any health care provider or facility: _____

[ ] Ok to leave a message: _____

This Release of Information will remain in effect until terminated by me in writing.

Signed: _____ Date: ___/___/___