CULLMAN INTERNAL MEDICINE

Dr. Harrison – Weight Loss - Lipovite

PATIENT'S PERSONAL HISTORY
BLACK INK ONLY
Confidential Record: Information contained here will not be released except when you have authorized us to do so.

Gender: MALE / FEMALE
LastName:_____Phone#:_____
First Name:_____Work orCell#:_____
Middle Name:_____Social Security #_____
Address:_____Birthday:_____
City:_____ State:_____Zip _____
Marital Status:_____Spouse Name:_____
Employer:_____Spouse Social #_____
Spouse Employer:_____Spouse work #:_____
E-Mail:_____Language:_____
Contact Preference: Phone / E-Mail / Mail Race:_____
Primary Insurance:_____ Ins #_____
Secondary Insurance:_____ Ins #_____

Previous Physician or Referring Physician_____
(Bring Ins. Cards, Medications, Medical Records, and New Patient Forms with you to your appointment)

Signature of Responsible Party _____ Date: _____
Person to notify in an Emergency(Not living in your household:
_____
Relationship_____ Phone# _____

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Late Cancellation Policy: Patients are responsible for canceling all scheduled appointments within 24 hours. **Failure to keep an appointment without giving at least 24 hours notice will generate a charge of $25.00 to the patients account.** The patient is responsible for this charge, which is non-billable to the insurance company.
Responsible Party:_____ Relationship to Patient:_____
I hereby authorize Cullman Internal Medicine P.C. to furnish to the above insurance company'(s) all information, which said insurance company, may request. I hereby assign to Cullman Internal Medicine P.C., all money to which I am entitled for medical/surgical expense relative to the service rendered but not to exceed my indebtedness to the professional corporation. I understand that I am financially responsible to the said corporation for charges not covered by this assignment, I further agree, in the event of nonpayment, to bear the cost of collection and /or court cost and responsible legal fees, should this be required.
I herby consent to any and all medical treatment which may be deemed advisable by his or her physician practicing at Cullman Internal Medicine.
Patient Signature:_____
Parent/Guardian Signature:_____

PAST MEDICAL HISTORY AND FAMILY HISTORY

SURGICAL HISTORY

What operations have you had?

_____

_____

ALLERGIES

Name any drug you are allergic to and what type reaction each drug causes _____

_____

_____

MEDICAL HISTORY

Write the names of any illness that have required hospitalization _____

_____

_____ Write the names of any serious illnesses you've had that did NOT require hospitalization

_____

_____

List any serious injuries or accidents _____

_____

DO YOU OR ANY OF YOUR BLOOD RELATIVES HAVE OR HAD ANY OF THE FOLLOWING:

Stroke _____ Epilepsy _____Heart Attack _____
Suicide _____ Cancer _____Goiter _____
High Blood Pressure _____ High cholesterol_____
Asthma _____ Hay Fever _____
Nervous Breakdown _____ Migraines _____TB_____
Stomach Ulcers _____Kidney Disease _____
Rheumatic Fever_____
Insanity _____Leukemia _____Diabetes_____
Arthritis _____ Bleeding Tendency _____
Congenital Heart Disorder _____ Colitis_____

PERSONAL HABITS (CIRCLE)

Yes No Do you regularly smoke? Cigarettes Pipe Cigars How many years? _____
Yes No Do you usually drink over six(6) cups of coffee per day?
Yes No Do you regularly drink alcohol?
1 oz per day 2 oz per day 4 oz per day over 6 oz per day

BEER	1 bottle per day	2 bottles per day	over 4 bottles per day
WINE	1 glass per day	2 glasses per day	over 4 glasses per day

Yes No Do you have difficulty falling asleep?

Cullman Internal Medicine
Medication List

Please list all of your current medications including the name of your medication, the dosage amount and the directions. Example – Nexium 40 mg once per day. Please include dietary supplements and vitamins

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____
18. _____