PRIMARY MEDICINE
ASSOCIATES

☐ Dr. Brian Wood ☐ Dr. Michael Canfield

NAME:_____

DOB:_____ SSN:_____

ADDRESS:_____

CITY_____STATE:_____ZIP:_____

PHONE(cell):_____(home):_____

E-MAIL:_____

EMERGENCY CONTACT (name/relationship/phone number):_____

_____

LAST PRIMARY PHYSICIAN:_____LAST SEEN:_____

INSURANCE COMPANY:_____GROUP #:_____

CONTRACT NUMBER:_____CO-PAY AMOUNT:_____

ANY CONCERNS YOU MAY HAVE AT THIS TIME:_____

_____

Our doctors do NOT write prescriptions for pain medication and other controlled substances.

890 N. Dean Road Suite 500, Auburn, AL 36830, Phone: (334)821-2708 Fax: (334)821-3309

Patient's Name:_____ date of birth:_____

Please list **ALL MEDICATIONS** you are currently taking (Prescription and over the counter)

Medications	Dosage	Frequency

Please List **ALL** Allergies

Allergies	Type of Reaction

☐ By checking this box, I am stating that I do not take any prescription or over the counter medications.

☐ By checking this box, I am stating that I do not have any known allergies.

Patient's Signature:_____ Date:_____

Complete Medical History Form

Past medical history

A. Current Medical Diagnosis (Hypertension, Diabetes, etc.):_____

_____

Surgeries/Procedures dates:

T&A (tonsils):_____ Appendectomy date:_____ Gallbladder:_____

Hysterectomy:_____ Ovaries removed: Yes No (circle) Vasectomy_____

Other surgeries:_____

Colonoscopy:_____ mammogram:_____ PAP_____

B. Injuries/Fractures: (type, date, and how injured):_____

_____

_____

Family history

Mother: Age (if living)____ Age (at death)_____ Cause of death:_____

List any medical problems she has had:_____

_____

Father: Age (if living)____ Age (at death)_____ Cause of death:_____

List any medical problems he has had:_____

_____

Brother(s) ages and any medical problems he/they have had:_____

_____

Sister(s) ages and any medical problems she/they have had:_____

_____

Any other blood relatives with: (mother=M, father=F, brother=B, sister=S, mother's mother= M/M, mother's father=M/F, father's mother=F/M, father's father=F/F, aunt=A, uncle =U)

Diabetes:_____ High Blood Pressure:_____

Heart Attack:_____ High cholesterol:_____

Stroke:_____ Tuberculosis:_____

Alzheimer's:_____

Cancer (please list):_____

Patient's Signature:_____ Date:_____

Lifestyle History

A. Alcohol Intake:

What do you usually drink?_____ how much?_____ how often?_____

_____Do not drink alcohol

B. Tobacco: _____ex-smoker _____never smoked

_____Current-Number of packs, pipes, cigars, dips per day?_____

When did you start smoking?_____ If ex-smoker, when did you quit?_____

C. Drugs/Substance Abuse: Type:_____ Frequency:_____

Still using: _____yes _____no

D. Work/Education:

Current occupation or school(year/major):_____

Any work related injuries?_____

E. Marital status: _____single _____married _____divorced

Is significant other _____male _____female

F. Have you ever been pregnant or do you have any children? ____yes ____no ____N/A

If yes, how many pregnancies/births/children?_____

Ages of children:_____

G. Diet: Usual number of meals per day?_____

Number of times per week you eat "fast food"?_____

H. Exercise: Do you exercise regularly?_____

What Activity?_____

How often?_____ How long is each session?_____

I. Immunizations: Check childhood shots given:

DPT_____ Mumps_____ Measles_____ Rubella_____ Polio_____

Smallpox_____ Tetanus Booster date_____ pneumonia vaccine date_____

Flu vaccine date_____ Hepatitis B (series of 3 shots)_____

Review of Systems

List any other problems, symptoms of concern to you:

Patient's Signature:_____ Date:_____