Lanier Family Healthcare

Gary S. Orris M.D

Patient Information Form

ALL PATIENTS OR RESPONSIBLE PARTIES MUST COMPLETE THIS FORM AND PROVIDE A PICTURE AND INSURANCE CARD BEFORE SEEING A DOCTOR

LAST NAME_____FIRST NAME_____M.I___

NAME YOU PREFER TO GO BY _____

ADDRESS_____CITY_____

STATE_____ZIP_____HOME PHONE_____CELL PHONE _____

BIRTHDATE_____

EMAIL_____SSN___-___-____

SEX (M) _____(F)_____ MARITAL STATUS: S M W D

REFERRED BY_____

EMERGENCY CONTACT_____**PHONE**_____

RELATIONSHIP TO THE PATIENT_____

IF PATIENT IS A MINOR, COMPLETE THE NEXT TWO LINES

FATHER'S NAME_____PHONE_____
MOTHER'S NAME_____PHONE_____

I HAVE PROVIDED THE OFFICE WITH A COPY OF THE FOLLOWING INFORMATION

INSURANCE CARD Y N

CURRENT CREDIT CARD Y N

PHOTO ID Y N

I AM SELF PAY Y

IN ORDER TO MAINTAIN CONTINUITY OF CARE, I GIVE PERMISSION TO LANIER FAMILY HEALTHCARE TO RELEASE MY MEDICAL RECORDS TO ANY SPECIALISTS, HOSPITALS OR MEDICAL FACILITIES ASSOCIATED WITH MY CARE.

SIGNED_____

THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE. I AUTHORIZE BENEFITS BE PAID DIRECTLY TO THE PHYSICIAN, I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE

SIGNED_____

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Patient History Form for Current Visit

Patient Name_____ Date of Birth_____

What medical concerns can we assist with today?

_____

Current Medications:

Medications	Dose (mg/mcg)	Number of times a day

Are you allergic to any medications? Yes No

If yes, to which medications? _____

Social History

Do you currently smoke or chew tobacco? Yes No If no, have you in the past? Yes No How many packs per day? _____

Do you drink alcohol, beer, or wine? Yes No If no, have you in the past? Yes No

How many drinks per week? _____

Do you currently drink coffee, pop, tea, or energy drinks? Yes No

Do you exercise daily/weekly? Yes No

Do you use seatbelts when driving? Yes No

Do you wear a helmet while riding a bike? Yes No

Have you have had any of these symptoms recently? (Please check)

Cough	Breathing problems	Abdominal pain
Change in Vision	Diarrhea	Hemorrhoids
Sinus pain	Eye pain/runny eyes	Pain with urination
Leg cramps	Dizziness	Urinating frequently
Bloody nose	Chest pain	Back pain
Swollen/painful joints	Vomiting	Foot/ankle pain
Allergy symptoms	Decreased hearing	Nerve pain
Heartburn	Fainting	Trouble sleeping/snoring
Thoughts of suicide	Palpitations	Sore Throat
Headache	Rash	Swollen lymph nodes

Past Medical History Form

Patient Name_____ Date of Birth_____

Have you ever been hospitalized overnight? Yes No

Immunizations (Enter dates if known)

Pneumonia	Tetanus	Typhoid
Gardasil	Shingles	Measles (MMR)
Hepatitis A	Polio	
Hepatitis B	Meningitis	

Which of the following conditions are you currently being treated or have been treated for in the past? (Please check the box)

High cholesterol	Hearing loss	Swollen ankles/vein problems
Low blood pressure	Kidney stones	Diabetes
High blood pressure	Eye disorder/glaucoma	Arthritis
Shortness of breath	Seizures	Thyroid problems
Asthma	Stroke	Corrective lenses/glasses
Lung Problems/cough	Headaches/migraines	Hernia
Sinus problems	Neurological problems	Bruising
Seasonal allergies	Depression/anxiety	Trouble sleeping
Tonsillitis	Psychiatric care	Changes in skin
Ear problems	Liver problems/hepatitis	Hair loss
Kidney/bladder problems	Ulcers/colitis	Heart Murmur/Angina
Cancer	Prostate problems	
Sexually transmitted disease	Rheumatic fever	
	Eating disorder	

Past Diagnostic studies and health maintenance: Have you ever had and when.

Any CT scan	Ultrasounds	Prostate check (male)
Stress test	Endoscopy	Eye exam
Colonoscopy	Bone Density	
Any MRI scans		

Please describe any current or past medical treatment not listed above

_____

Please list your past surgeries

_____

_____

_____

Family History

Please list the members of your family (including children and parents) that have had any treatable conditions

Family Members	Living	Age /Age if deceased	Condition	
Father				
Mother				
Spouse				
Brother(s)				
Sister(s)				
Children				
Grandmother				
Grandfather				

Females: Gynecological History

First day of your last menstrual period?_____

How many times have you been pregnant? _____ outcome?_____

Date of last Pap smear _____

Have you had an abnormal Pap smear? Yes No

Date of last mammogram? _____

Have you ever had a breast biopsy? Yes No

Pharmacy that you want to use: _____

City_____ Phone# _____

I consent to allow Lanier Family Healthcare to request my Medication History, from any heath provider

Name of previous physician

_____