SYCAMORE MEDICAL CLINIC

Michael S. Gorby, MD, FACP
Board Certified Internal Medicine
Board Certified Critical Care

Carolyn F. Salter, MD
General Practice
Board Certified Anesthesiology

Natalie Burks, RN, FNP-C
Board Certified Family Medicine

Stephanie L. Byrd, RN, FNP-C
Board Certified Family Medicine

Patient Information

Name: _____ Preferred Name: _____

Mailing Address: _____City, State, Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Date of Birth: _____ Sex: _____ Social Security #: _____

Race: _____ Ethnicity: _____ Primary Language: _____

E-mail Address: _____

Marital Status (circle): single married divorced widowed legally separated other

Preferred Pharmacy: _____ City:_____ State:_____

Please list appt reminder call preference: O Text O Voice Call #_____

How did you hear about us? _____

_____

Responsible Party Name or Power of Attorney (**if patient is a minor or if Power of Attorney is applicable**): _____

Relation: _____ Home Phone: _____ Cell Phone: _____

Date of Birth: _____ Social Security #: _____

Mailing Address: _____City, State, Zip Code: _____

_____

Emergency Contact Name: _____

Mailing Address: _____City, State, Zip Code: _____

Relation: _____ Home Phone: _____ Cell Phone:_____

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Name: _____ Date of Birth: _____

Primary Insurance: _____ Customer Service Phone #: _____

Claims Address: _____

Member/Subscriber ID: _____ Group #: _____

Policy Holder Name: _____ DOB: _____

Policy Effective Date: _____

Secondary Insurance: _____ Customer Service Phone #: _____

Claims Address: _____

Member/Subscriber ID: _____ Group #: _____

Policy Holder Name: _____ DOB: _____

Policy Effective Date: _____

Prescription Insurance: _____ Customer Service Phone #: _____

ID: _____ BIN #: _____ Group #: _____ PCN: _____

Do you have any form of Medicaid (circle one)? Yes No

INSURANCE AUTHORIZATION AND ASSIGNMENT

I authorize Sycamore Medical Clinic to release to my insurance carrier and/or their agents any information necessary to determine benefits payable for related services. I authorize the payment of medical benefits to Sycamore Medical Clinic. I understand that I am ultimately responsible for all services whether covered by insurance or not.

Signature: _____ Date: _____

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Patient History Questionnaire

Name: _____Date of Birth:_____

**The following form will provide our office the information needed to determine if we are a good fit to care for your medical needs. This entire form must be completed. Failure to disclose medical history or medication, or intentionally lying, may result in discharge from the practice.

Are you currently being treated by other doctors? Yes No

If **yes**, please list their names, specialty and phone numbers:_____

_____

_____

Who is your previous primary care physician?_____

What is your reason for changing providers?_____

_____

What is the reason for your office visit today?_____

_____

Childhood Illnesses

Were you healthy as a child? Yes No

Please list illnesses, injuries and/or hospitalizations. Examples are tonsillectomy, chicken pox, fractures, etc:_____

_____

_____

Immunizations

Did you have the usual childhood immunizations? Yes No

What year was your last tetanus (lockjaw) shot? _____

Have you ever had a tuberculosis skin test? Yes No Was it positive or negative? _____

Have you ever had the pneumonia vaccine? Yes No If **YES**, when? _____

Have you ever had the Hepatitis B vaccine series? Yes No If **YES**, when? _____

When was your last flu shot? _____

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Name: _____ Date of Birth: _____

Health Maintenance

For the following procedures, please list date, result & facility of the most recent.

Chest x-ray: _____

EKG (electrocardiogram): _____

Colonoscopy: _____

Mammogram (females only): _____

Annual PAP or Prostate exam: _____

Bone density scan: _____

PSA (males only): _____

Adult Illnesses

Anemia Y N

Arthritis Y N

Asthma Y N

Cancer Y N

Easy bleeding/bruising Y N

Glaucoma Y N

Heart disease Y N

High blood pressure Y N

Chest Pain Y N

Seizures or epilepsy Y N

Stroke Y N

Diabetes Y N

Goiter Y N

Tuberculosis Y N

Sexually transmitted disease Y N

Emotional problems Y N

Explain any **YES**:

_____

_____

_____

Hospitalizations/Surgeries

Illness/Surgery	Date	Hospital
1 _____	_____	_____
2 _____	_____	_____
3 _____	_____	_____
4 _____	_____	_____
5 _____	_____	_____

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Name: _____ Date of Birth: _____

Medications

Are you currently taking any medications including non-prescription? Yes No If **YES**, please list below?

Medication	Frequency	Strength
1 _____	_____	_____
2 _____	_____	_____
3 _____	_____	_____
4 _____	_____	_____
5 _____	_____	_____
6 _____	_____	_____
7 _____	_____	_____
8 _____	_____	_____
9 _____	_____	_____
10 _____	_____	_____

Please be advised, Sycamore Medical Clinic does not accept NEW patients that are taking multiple controlled substance medications. Those controlled substances MUST be managed by a pain doctor or psychiatrist.

_____ I understand and agree to this policy prior to scheduling an appointment. Please initial.

Medication Allergies

Are you allergic to, or have had a reaction to any medication or other substance? Yes No

If **YES**, please list below?

Medication	Reaction
1 _____	_____
2 _____	_____
3 _____	_____
4 _____	_____

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Name: _____ Date of Birth: _____

Social History

Do you use alcohol? Yes No If **YES**, how often on a weekly basis? _____

Have you ever been a "heavy drinker"? Yes No

Do you use tobacco? Yes No If **YES**, what age did you start? _____ What form of tobacco do you use? _____ How much do you use daily? _____

If a previous smoker, how many packs daily? _____ What year did you quit? _____

Do you get any form of cardio/aerobic exercise? Yes No If **YES**, how many times per week and duration? _____ What forms of exercise? _____

_____

What is your place of birth? _____

What is your marital status? _____ If currently married, what is your spouse's name? _____ Occupation? _____

How many previous marriages? _____ Do you have any children? Yes No If **YES**, how many? ____ What year(s) were they born? _____ Do any of your children have health problems? Yes No If **YES**, please explain: _____

_____

Do you currently work? Yes No If **YES**, where are you currently employed and when did you begin? _____ What is your current position? _____

Family History

Father Birth year _____ Living? Y N Past/Present Illnesses: _____

_____

Mother Birth year _____ Living? Y N Past/Present Illnesses: _____

_____

Brother or Sister (circle one) Birth year _____ Living? Y N Past/Present Illnesses:

_____

Brother or Sister (circle one) Birth year _____ Living? Y N Past/Present Illnesses:

_____

Brother or Sister (circle one) Birth year _____ Living? Y N Past/Present Illnesses:

_____

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Name: _____ Date of Birth: _____

Family History (continued)

Brother or Sister (circle one) Birth year _____ Living? Y N Past/Present Illnesses:

_____

Brother or Sister (circle one) Birth year _____ Living? Y N Past/Present Illnesses:

_____

Paternal grandmother Birth year _____ Living? Y N Past/Present Illnesses:

_____

Paternal grandfather Birth year _____ Living? Y N Past/Present Illnesses:

_____

Maternal grandmother Birth year _____ Living? Y N Past/Present Illnesses:

_____

Maternal grandfather Birth year _____ Living? Y N Past/Present Illnesses:

_____

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Name: _____Date of Birth:_____

FEMALE REVIEW OF SYMPTOMS

Please check any of the following symptoms that you currently have.

General

Unusual weight gain____ Unusual weight loss____ Fatigue____ Fever____ Chills

Head

Headache____ Head injury____ Trauma_____

Eyes

Difficulty with vision____ Wear glasses/contacts_____ Pain in eyes____

Ears/Nose/Throat

Hard of hearing_____ Ringing in ears_____ Earaches____ Nasal stuffiness____ Hay fever/allergies____ Nose bleeds____ Sore throat ____

Lungs

Wheezing ____ Persistent cough____ Pain when breathing____ Shortness of breath____

Heart

Chest pain____ Palpitations____ Swelling of ankles____

Gastrointestinal System

Indigestion____ Sick to the stomach ____ Vomiting____ Stomach pain____
Diarrhea____ Constipation_____ Blood in bowel movements____

Urinary

Frequent urination____ Burning or pain when urinating____ Blood in urine____ Can't control urine ____

Musculoskeletal

Joint pain/stiffness____ Gout____ Backache____ Muscle cramps____ Muscle pain____

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Name: _____Date of Birth:_____

Neurological

Fainting____ Seizures____ Tingling of hands/feet____ Difficulty with memory____

Psychological

Depression____ Anxiety ____

Blood

Bleeding easily ____ Bruising easily ____

Women

Breast pain ____ Breast lump ____ Prolonged menstrual bleeding ____ Irregular menstrual bleeding ____

Other

List any other symptoms not included from above:

_____
_____
_____
_____
_____

Please list any other pertinent information:

_____
_____
_____
_____
_____