Medical History

Patient Data Sheet updated ________

Name ______________________________
Date ______________ SS# ______________
Address ______________________________
Occupation ______________ Phone (home) ______________
Phone (work) ______________ Date of Birth ______________
Reason for visit

Hospitalizations or Surgery

Date	Reason	Date	Reason

Drug Allergies/ Reactions

Medications

Vaccine	Year of Last	Vaccine	Year of Last	Test	Year of Last	Test	Year of Last
Tetanus		Pneumonia		Rectal/Stool		Tuberculosis	
Flu		Other		Cholesterol		Other	

Medical History & Review of Systems

- ☐ Ringing In Ear
- ☐ Ear Infections – frequent
- ☐ Dizziness/ Fainting
- ☐ Failing vision
- ☐ Eye Infections
- ☐ Nose Bleeds
- ☐ Sinus Trouble
- ☐ Sore Throats – Frequent
- ☐ Hayfever/ Allergies
- ☐ Pneumonia
- ☐ Bronchitis/ Chronic Cough
- ☐ Asthma/ Wheezing
- ☐ Chest Pain
- ☐ High Blood Pressure
- ☐ Heart Murmur
- ☐ Swollen Ankles
- ☐ Leg Pain – Walking
- ☐ Varicose Veins/ Phlebitis
- ☐ Loss of Appetite
- ☐ Difficulty Swallowing
- ☐ Indigestion or Heartburn
- ☐ Persistent Nausea/ Vomiting

- ☐ Gall Bladder Trouble
- ☐Jaundice / Hepatitis
- ☐Change in Bowel Habits
- ☐Diarrhea / Constipation
- ☐Diverticulosis / Crohn's / Colitis
- ☐Bloody or Tarry Stools
- ☐Hemorrhoids
- ☐Hernia
- ☐Urine Infections Frequent
- ☐Urination >2times over night
- ☐Urination, painful or loss of control
- ☐Urination, decrease in force or flow
- ☐Kidney Stones
- ☐Venereal Disease
- ☐Urethral Discharge
- ☐Chronic Fatigue
- ☐Weight loss, unexplained
- ☐Anemia or easy bruising
- ☐Cancer
- ☐Diabetes
- ☐Thyroid Disease
- ☐Seizures

- ☐Stroke
- ☐Muscle Weakness
- ☐Numbness/ Tingling sensation
- ☐Headaches, frequent
- ☐Arthritis / Rheumatism
- ☐Osteoporosis
- ☐Back Pain, recurrent
- ☐Bone Fracture / Joint Injury
- ☐Gout
- ☐ Foot Pain or Cold Numb Feet
- ☐Rashes or Hives
- ☐Psoriasis or Eczema
- ☐Nervousness or Depression
- ☐Memory loss
- ☐Moodiness, Excessive
- ☐Phobias
- ☐Mental Illness
- ☐Lactose Intolerance
- ☐Prostate Disease
- ☐Sexual/ Menstrual Dysfunction
- ☐Frequent Infections
- ☐Diphtheria

- ☐Tetanus
- ☐Chicken Pox or Polio or Mumps
- ☐other ______________
- ☐other ______________
- ☐**Females:**

Pregnant? ☐ yes ☐ no
Planning Pregnancy? ☐ yes ☐ no
Menstrual Flow:☐
☐Regular ☐ Irregular ☐ Pain/Cramps
___Days of Flow __Length of Cycle
Date: 1st day of last period________
☐Pain/Bleeding during or after sex
____ Pregnancies ____ Abortions
____ Miscarriages ____ Live Births
Birth control method ____________
☐BC Pill (name) ____________
☐Flushing/Menopause
Date of Last PAP Test ____________
☐Normal ☐ Abnormal
Date of last mammogram __________
☐Normal ☐ Abnormal

Family History

	Father	Mother	Children	Siblings	Father's Parents	Mother's Parents
Alcoholism	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐
Seizures	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐

	Father	Mother	Children	Siblings	Father's Parents	Mother's Parents
High Blood Pressure	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐
Migraine	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐
Other: __________	☐	☐	☐	☐	☐	☐

Social History

Diet: Diabetic______________
Low Fat ______________
Diet Needs Work?

Alcohol: Type ______________
Amount ______________
Exercise Routine:

Smoke/Chew: How long _____
How much? ______________
Interested in stopping?

Sexually Active? ____________
Homosexual? ____________
Heterosexual?

Doctors Notes

CMP Lipids PSA TSH CBC
Sched Mammogram Flex Sig

- ☐ PMH,SH.FH,Meds reviewed, updated
- ☐ Patient Data sheet rev. and updated
- ☐ Safe exercise routine discussed
- ☐ Healthy diet, exercise discussed.
- ☐ ROS negative except as noted

Time Min 50% Counseling

Greater Athens Physicians, Inc.

Paul D. Haver, M.D. and J. Michael Shiver, M.D.

Athens, GA

PATIENT INFORMATION

Last Name	First Name	Middle Initial	Nick Name
Street Address	Apt, Lot # or PO Box	City, State, Zip	
Sex M / F	Employer Name address	Student Full time/Part Time	
Home Phone	Work Phone Ext	Cell Phone	
Date Of Birth / Social Security Number	Marital Status	Spouse's Name	
Referred By	Relative or Friend not living with you		
Relative/Friend Address	Relative/Friend Phone	Relationship	

INSURED PARTY INFORMATION

Insured's Last Name	Insured's First Name	Insured's Middle Name
Sex M / F / Insured's Date of Birth	Insured's Home Address	City, State & Zip
Insured's Social Security #	Insured's Home Phone	Insured's Work Phone
Insured's Employer	Insured's Employer Address and Phone Number	

PRIMARY INSURANCE INFORMATION

Please present your card/s to the receptionist so she may copy the card for your file. Thank you

Insurance Company's Name	(HMO,PPO,POS,etc)	Attention To:
Insurance Address		City, State and Zip
Insurance Company's Phone Number	Insurance Group Name / Number	Effective Date of Insurance
Insurance Insured's ID #	Patient's Relationship to the Insured (Self, Spouse, Child, etc)	

SECONDARY INSURANCE INFORMATION

Insurance Company's Name		Attention To:
Insurance Address		City, State and Zip
Insurance Company's Phone Number	Insurance Group Name / Number	Effective Date of Insurance
Insurance Insured's ID #	Patient's Relationship to the Insured (Self, Spouse, Child, etc)	

Insurance Payment

All services rendered are charged to the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. Payment is due at the time of service.

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the physician of the surgical and/or medical benefits, if any, otherwise payable to me for his/her services as described realizing that I am responsible to pay non-covered services.	Signature Date
AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the physician to release any information required in the course of my treatment necessary to process insurance claims.	Signature Date