Marietta Medical Clinic

2520 Windy Hill Rd. Suite #306
Marietta, GA 30067
Office: 770-955-1814 Fax: 770-955-2279

What is the purpose for your visit today?

_____
_____
_____

Would you like to receive a FLU SHOT today, if not received yet?

_____ Yes
_____ No

Medication List

◯ No Changes
◯ New Medications

_____
_____
_____

Pharmacy #: _____

Any recent hospital or doctor visits?

◯ No
◯ Yes

If yes, what is your doctor's name & specialty? _____

Updates in your insurance coverage?

◯ No
◯ Yes

_____

Any updates on your contact information or phone number?

_____
_____

_____ _____ _____

Patient's Signature Patient's Name (PRINT) Date

Medial History **Date _____**

Name _____ DOB _____ Age _____
Address _____ Sex: Female or Male
_____ Home Phone _____
_____ Cell Phone _____
Occupation _____ Emergency Contact _____
Phone _____
◯ Single ◯ Married ◯ Divorced ◯ Widowed ◯ Separated
If married, spouse's name _____
Children's name & ages _____

Allergies to medications, X-Ray, Dyes, or Other Substances? ◯ No ◯ Yes
(If yes, please list name of medications and type of reactions)

_____ _____
_____ _____
_____ _____
_____ _____

Past Medical History and Review of Systems
(Please check off if you have any problems with or are presently experiencing any of the following):

o High Blood Pressure	o Bronchitis	o Change in bowel habits	o Arthritis
o Diabetes	o Pneumonia	o Unexpected weight gain/loss	o Low back problems
o Cancer	o Persistent Cough	o Hemorrhoids	o Blood Disorders
o Heart disease	o T.B.	o Gallbladder disease	o Venereal disease
o Chest pain/tightness	o Hay fever	o Shortness of breath	o Indigestion
o Swollen ankles	o Nausea	o Abdominal discomfort	o Colitis
o Anxiety	o Hepatitis or Jaundice	o Palpitations	o Vomiting
o Head or Neck radiation	o Constipation	o Headache	o Lightheadedness
o Frequent urination	o Diarrhea	o Kidney disease	o Gout
o Rheumatic fever	o Blood in stool	o Kidney stones	o Impotence or erectile dysfunction
o Asthma	o Ulcers	o Difficulty urinating	

Other:
_____
_____
_____

Medical History **Date _____**

Name _____

Please List & Supply the Dates of:

Operations:

_____

_____

Hospitalizations other than for surgery:

_____

_____

Immunization History – have you had:

Hepatitis B ○ No ○ Yes When?_____ Pneumovax ○ No ○ Yes When? _____

Flu ○ No ○ Yes When? _____ Tetanus ○ No ○ Yes When? _____

Other ○ No ○ Yes When? _____

When was your last:

Pap Smear? _____ Breast Exam? _____

Stool check for blood?_____ Mammogram? _____

Cholesterol Check? _____ Prostate Exam? _____

Family History: Has any member of your family (including parents, grandparents, & siblings) ever had the following?

	Which family member?	Age when diagnosed?
Cancer (describe type)	_____	_____
Hypertension (high blood pressure)	_____	_____
Heart Disease	_____	_____
Diabetes	_____	_____
Strokes	_____	_____
Mental disease (anxiety/depression)	_____	_____
Drug or Alcohol addiction	_____	_____
Glaucoma	_____	_____
Bleeding disease	_____	_____

Medications: (Prescription, over-the-counter, vitamins, herbs, etc.)

Drug Name	Dose	Drug Name	Dose	Drug Name	Dose
_____		_____		_____	
_____		_____		_____	
_____		_____		_____	

INDIRA DEVU, MD

Acknowledgement of Receipt of Information
"NOTICE OF PRIVACY PRACTICES"

I acknowledge that I have reviewed the Notice of Privacy Practice given to me by the Marietta Medical Clinic protected health information on the date set forth below.

_____ _____
Date Reviewed Patient Date of Birth

_____ _____
Print Patient Name Print Name of Authorized Representative

_____ _____
Patient Signature Signature of Authorized Representative

_____
Indicate Relationship to Relative

FOR USE BY MARIETTA MEDICAL CLINIC PERSONNEL ONLY
(Complete if patient acknowledgement is NOT obtained)

An Acknowledgement of Receipt of Notice of Privacy Practice was not received/signed due to patient:

◯ Refusal to sign Acknowledgement
◯ Communication, language or other barrier prevented signature
◯ Emergency treatment situation
◯ Other (please explain): _____

_____
Signature of Marietta Clinic Representative Date

Gynecology and Obstetric History

Age at onset of menstrual cycle _____ Frequency _____ Length of menstrual cycle _____
Pregnancies _____ Births _____ Miscarriages _____
Leakage of urine ○ No ○ Yes (please describe) _____
Pelvic Pain ○ No ○ Yes (please describe) _____
Abnormal discharge ○ No ○ Yes (please describe) _____
History of normal Pap Smear ○ No ○ Yes (please describe) _____

Prevention

Do you wear seat belts? ○ Yes ○ No (If no, why not?) _____
Do you wear a bike helmet? ○Yes ○ No ○ N/A
Do you exercise regularly? ○ Yes ○ No (If yes, type, duration & number of times) _____
Do you smoke? ○ Yes ○ No (If yes, how many packs per day?) _____
Do you drink alcohol beverages? ○ Yes ○ No (If yes, how much per week?) _____
Do you drink coffee? ○ Yes ○ No (If yes, how many cups per day?) _____
Do you drink tea? ○ Yes ○ No (If yes, how many cups per day?) _____
If there is a gun in your home, do you keep it unloaded & out of reach of children? ○ Yes ○ No ○ N/A
Do you use drugs (Marijuana, cocaine, crack, etc.)? ○ Yes ○ No (If yes, explain) _____
Have you engaged in any activity which has put you at risk of getting AIDS? ○ Yes ○ No (If yes, explain) _____
Do you wish to get tested for AIDS? ○ Yes ○ No (If yes, explain) _____
Have you worked with chemicals, paints, asbestos or other hazardous materials? ○ Yes ○ No (If yes, explain) _____
Are you in a relationship in which you have been physically hurt by your partner? ○ Yes ○ No (If yes, explain) _____
Do you ever feel afraid of your partner? ○ Yes ○ No ○ N/A
Do you have a “living will”? ○ Yes ○ No
Do you have a donor card? ○ Yes ○ No
Method of Birth Control _____

Pharmacy

Pharmacy Name _____
Pharmacy Number _____

LABORATORY TESTING CONSENT

The purpose of these laboratory tests is to provide better patient care. The labs may consist of testing for patient blood type, Hepatitis, syphilis, HIV, and other STDs. We may also perform a drug screening if medically necessary.

The laboratory in our facility does not work for Marietta Medical Clinic. Any bills that are billed by them is the patient's insurance responsibility or the patient's responsibility.

I have reviewed the above information. I have had the opportunity for my questions concerning these tests and their limitations to be answered.

_____
Date

_____
Patient Name

_____ _____
Patient Signature Witness

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO INDIVIDUALS/FAMILY MEMBERS

In accordance with Federal government privacy rules implemented through the Healthcare Portability Act of 1996 (HIPPA), in order for your healthcare provider or staff of Marietta Medical Clinic to discuss your condition with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

_____ I **do** authorize Marietta Medical Clinic to release any or all information concerning my medical care to any individual except as set for above.

_____ I **do not** authorize Marietta Medical Clinic to release any or all information concerning my medical care to the following individuals:

_____	_____
Name	Relationship to Patient
_____	_____
Name	Relationship to Patient
_____	_____
Name	Relationship to Patient
_____	_____
Name	Relationship to Patient

_____ _____

Patient Signature Date

_____

Print Patient Name Date of Birth Social Security Number

_____ _____

Witness Signature Date

Wellness/CPE

Patient Name _____ Date _____

(PLEASE LIST DATE OF EXAM)

1. EYE DOCTOR _____/_____/_____

2. COLONSCOPY (50 YRS+) _____/_____/_____

3. MAMMOGRAM (40 YRS+) _____/_____/_____

4. LAST PAP _____/_____/_____

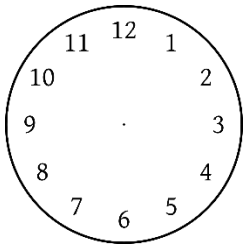
5. PROSTATE EXAM (MALES 40 YRS+) _____/_____/_____

6. VACCINATIONS:
   - A. FLU SHOT _____/_____/_____
   - B. PNEUMONIA (60 YRS+) _____/_____/_____
   - C. HPV VACCINE (LESS THAN 26 YRS) _____/_____/_____
   - D. SHINGLES (60 YRS+) _____/_____/_____
   - E. TETANUS EVERY 10YRS _____/_____/_____

7. HEARING LOSS ○ YES ○ NO

8. ADVANCE DIRECTIVE/LIVING WILL (IF NOT, DO YOU NEED INFO. ABOUT GETTING ONE)

9. RISK OF FALLING ○ YES ○ NO



10. MEMORY LAPSE ○ YES ○ NO

11. DETAILED FAMILY HISTORY:
    (MOM, DAD, SISTER, BROTHER, AUNT, UNCLE, GRANDPARENTS, CHILDREN)
    - -MI (HEART ATTACK) _____
    - -DM _____
    - -CVA (STROKE) _____
    - -CANCER _____
    - -LUNG DISEASE _____

12. SMOKING/ALCOHOL – HOW MUCH/ HOW LONG _____

13. DEPRESSION/ANXIETY _____

14. DEXA SCAN (60 YRS+) _____/_____/_____

15. EXERCISE _____

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Depression Level 0-4 (None) 5-9 (Mild) 10-14 (Moderate) 15-19 (Moderate-Severe) 20-27 (Severe)