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___

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_____

5830 Bond Street Suite 200A Cumming GA 30040 770-205-5518/phone 770-205-5519 fax
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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
☐Change in Vision
☐Sinus pain
☐Leg cramps
☐Bloody nose
☐Swollen/painful joints
☐Allergy symptoms
☐Heartburn
☐Thoughts of suicide
☐Headache
☐Breathing problems
☐Diarrhea
☐Eye pain/runny eyes
☐Dizziness
☐Chest pain
☐Vomiting
☐Decreased hearing
☐Fainting
☐Palpitations
☐Rash
☐Abdominal pain
☐Hemorrhoids
☐Pain with urination
☐Urinating frequently
☐Back pain
☐Foot/ankle pain
☐Nerve pain
☐Trouble sleeping/snoring
☐Sore Throat
☐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
☐Gardasil
☐Hepatitis A
☐Hepatitis B
☐Tetanus
☐Shingles
☐Polio
☐Meningitis
☐Typhoid
☐Measles (MMR)

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

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

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

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

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

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