Quail Ridge Family Practice, LLC
1 Doctors Park – Cairo, GA 39828
Phone 229-378-8110 Fax 229-378-8109

Patient Information

Patient Name **Date of Birth** **Age**

Home Address **City** **State** **ZIP**

Preferred (alternate) Mailing Address **City** **State** **ZIP**

Contact Phone Numbers: ****Circle the phone number you prefer us to use. ** Check the box if it is okay to leave a message.**

Home Phone ☐ Okay to leave a message **Work Phone** ☐ Okay to leave a message **Cell Phone** ☐ Okay to leave a message

Patient E-mail Address **Pharmacy**

Sex ☐ Male ☐ Female **Language** ☐ English ☐ Spanish ☐ Other _____

Social Security Number **Driver's License Number**

RACE
☐ White ☐ Hispanic ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ Asian ☐ American Indian/Alaska Native ☐ Other

ETHNICITY
☐ Hispanic ☐ Non-Hispanic ☐ Unknown ☐ Other

MARITAL STATUS
☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Domestic Partner

Employer/School **Occupation**

Employer Address **City** **State** **ZIP**

Employer Phone

Spouse's Name **Spouse's Employer**

Previous Physician's Name **Whom may we thank for referring you to our practice?**

Do you have a living will? Yes ____ No ____ (If yes, please provide us with a copy)

Responsible Party Information - For Payment (Parent/Guardian if patient is under 18 years of age)

Name **Date of Birth** **Relationship to Patient**

Address **City** **State** **ZIP**

Home Phone **Work Phone** **Cell Phone**

Social Security Number (for insurance purposes only)

Emergency Contact

Name **Relationship to Patient**

Address **City** **State** **ZIP**

Home Phone **Work Phone** **Cell Phone**

Name of Nearest Relative (not living with patient) **Relationship to Patient**

Home Phone **Work Phone** **Cell Phone**

Signature _____ **Today's Date** _____/_____/_____

Quail Ridge Family Practice, LLC

Mark C Hudson, DO, FAAFP
1 Doctors Park
Cairo, GA 39828
Phone (229) 378-8110
Fax (229) 378-8109

Date: _____/_____/_____

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name:	☐ M ☐ F	**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		
Previous or referring doctor:		**Date of last physical exam:**

PERSONAL HEALTH HISTORY

Childhood Illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio		
Immunizations and dates:	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Chickenpox
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella*

List any medical problems that other doctors have diagnosed

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion?	☐ Yes	☐ No

Name: _____ DOB: _____

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken
Allergies to medications		
Name the Drug	Reaction You Had	

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL						
Exercise	☐ Sedentary (no exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4 times per week for 30 minutes)					
	☐ Regular vigorous exercise (i.e., work or recreation 4 times per week for 30 minutes)					
Diet	Are you dieting				☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?				☐ Yes	☐ No
	Number of meals you eat in an average day?					
	Rank salt intake	☐ High	☐ Med	☐ Low		
	Rank fat intake	☐ High	☐ Med	☐ Low		
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	Number of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	If yes, what kind?					
	How many drinks per week?					
	Are you concerned about the amount you drink?				☐ Yes	☐ No
	Have you considered stopping?				☐ Yes	☐ No
	Have you ever experienced blackouts?				☐ Yes	☐ No
	Are you prone to “binge” drinking?				☐ Yes	☐ No
	Do you drive after drinking?				☐ Yes	☐ No
Tobacco	Do you use tobacco?				☐ Yes	☐ No
	☐ Cigarettes – packs/day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day		
	☐ # of years	☐ Or year quit				
Drugs	Do you currently use recreational or street drugs?				☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?				☐ Yes	☐ No

Name: _____ DOB: _____

Sex	Are you sexually active	☐ Yes	☐ No
	If yes, are you trying for a pregnancy?	☐ Yes	☐ No
	If not trying for a pregnancy, list contraceptive or barrier method used:		
	Any discomfort with intercourse?	☐ Yes	☐ No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?	☐ Yes	☐ No
Personal Safety	Do you live alone?	☐ Yes	☐ No
	Do you have frequent falls?	☐ Yes	☐ No
	Do you have vision or hearing loss?	☐ Yes	☐ No
	Do you have an Advance Directive or Living Will?	☐ Yes	☐ No
	If yes, please provide our office with a copy.		
	Would you like information about an Advance Directive or Living Will?	☐ Yes	☐ No
	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

MENTAL HEALTH

Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

Name: _____ DOB: _____

WOMEN ONLY

Age at onset of menstruation:		
Date of last menstruation:		
Period every _____ days		
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Number of pregnancies _____ Number of live births _____		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Have you had a D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Any problems with control of urination?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No
Date of last pap and rectal exam:		

MEN ONLY

Do you usually get up to urinate during the night?	☐ Yes	☐ No
If yes, # of times _____		
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Do you feel burning discharge from penis?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No
Date of last prostate and rectal exam:		

OTHER PROBLEMS

Check the boxes below if you have, or have had, any symptoms in the following areas and briefly explain.

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	

Signature _____ Date _____

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Insurance Information	
Primary Insurance	**Secondary Insurance**
Subscriber Name _____	Subscriber Name _____
Social Security Number _____	Social Security Number _____
Date of Birth _____	Date of Birth _____
Insurance Company _____	Insurance Company _____
Insurance ID# _____	Insurance ID# _____
Group # _____	Group # _____

Authorization for Treatment / Release of Information / Assignment of Insurance Benefits

The undersigned hereby grants authorization for such treatments and procedures that are deemed necessary and understands that such treatments and procedures may be performed by physicians, nurse practitioners, physician assistants. I hereby authorize Quail Ridge Family Practice to release all protected health information necessary to secure payment, to carry out treatment, and to carry out health care operations.

I certify that I, and/or my dependent(s), have insurance coverage with the above named insurance company.
I hereby assign all medical and/or surgical benefits to which I am entitled including major medical, Medicare, private insurance and any other health plans to Quail Ridge Family Practice, LLC. I will be held financially responsible for any non-covered benefits, deductibles or any co-payments for services which have been provided to me. I understand that I am financially responsible for all charges whether or not paid by said insurance. ***It is my responsibility to understand my insurance benefits and plan coverage.***

This agreement will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered as valid as an original.

Payment is expected at the time services are rendered.

_____ _____

Signature of Patient / Legal Representative Date