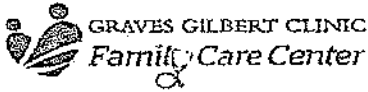


Dr. Brian Macy & Dr. Lindsey Whiteman
Family Medicine and Sports Medicine
2724 Nashville Rd, Bowling Green, KY
Phone (270) 782-4755 - Fax (270) 393-2738

MRN NUMBER:

New Patient Information

Name: ______________________________ **Date of Birth:** ___/___/____ **Today's Date:** ___/___/____

Medical History: Please circle *or list* any medical condition that applies to you

diabetes   high blood pressure   high cholesterol   heart attack/blockage   previous stroke   atrial fibrillation   migraines
depression / anxiety   under / over-active thyroid   chronic back pain   pain management   Rheumatism   Cancer (list type)

____
____
____

Surgical History: Please circle *or list* any previous surgery you have had (including the year it was done if known)

gallbladder _____   appendix _____   hysterectomy / ovaries removed _____   tonsils / adenoids removed _____
thyroid removed _____   L/R breast removed _____   back/neck surgery _____   weight loss surgery _____   knee replacement _____

____
____

Family History: Please circle any *listed* health conditions that exist in *these members* of your family if applicable

Father:	heart attack	stroke	diabetes	cancer________________	other ________________
Mother:	heart attack	stroke	diabetes	cancer________________	other ________________
Brother:	heart attack	stroke	diabetes	cancer________________	other ________________
Sister:	heart attack	stroke	diabetes	cancer________________	other ________________

Personal History: Please circle and/or complete all that apply to you

Occupation (former if retired or disabled): ____________________ Retired   Disabled   Student __________

Married: Yes to ________________   No   Divorced ____ time(s)   Number of children: ______

Nicotine: Never smoked   Current smoker ____ packs/day for ____ years   Former smoker ____ packs/day for ____ years
Never used tobacco   Currently: vape   chew/dip ____ times per week   Formerly: vape   chew/dip ____ times per week

Alcohol: Never   Occasionally   Rarely   Often: ____ drinks per week   Recovering alcoholic

Medications: Please list ***ALL*** medications you take, including non-prescription and herbal supplements

Drug	Strength	*Directions / times per day*	Drug	Strength	*Directions / times per day*

Additional meds written on back of page (circle this please)

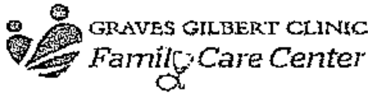
Allergies / adverse reactions: Please list any allergy or reaction to medications *OR* foods that apply to you

Medication / Food / Other	*Reaction (e.g., rash, swelling)*	Medication / Food / Other	*Reaction (e.g., rash, swelling)*

Additional reactions written on back of page (circle this please)

Pharmacy: Please indicate the pharmacies to where you would like your prescriptions sent electronically

Local: ______________________________ Mail Order: ______________________________



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Phone (270) 782-4755 - Fax (270) 393-2738

Patient Name: ______________________

Patient DOB: ______________________

New Patient Information – Family Medicine ONLY

MALE

1. Have you ever had a **COLONOSCOPY**? ( ) YES ( ) NO
   a. Date of most recent: ______________________
   b. Location of most recent: ______________________
   c. RESULTS: ( ) NORMAL ( ) ABNORMAL

FEMALE

1. Have you ever had a **COLONOSCOPY**? ( ) YES ( ) NO
   a. Date of most recent: ______________________
   b. Location of most recent: ______________________
   c. RESULTS: ( ) NORMAL ( ) ABNORMAL
2. Have you ever had a **PAP SMEAR**? ( ) YES ( ) NO
   a. Date of most recent: ______________________
   b. Location of most recent: ______________________
   c. RESULTS: ( ) NORMAL ( ) ABNORMAL
3. Have you ever had a **MAMMOGRAM**? ( ) YES ( ) NO
   a. Date of most recent: ______________________
   b. Location of most recent: ______________________
   c. RESULTS: ( ) NORMAL ( ) ABNORMAL
4. Have you ever had a **DEXA /BONE DENSITY TEST**? ( ) YES ( ) NO
   a. Date of most recent: ______________________
   b. Location of most recent: ______________________
   c. RESULTS: ( ) NORMAL ( ) ABNORMAL

Pain Management Agreement Name ________________ FA

Date of Birth____________

The purpose of this Agreement is to prevent misunderstandings about medicines you will be taking for pain management, and to help both you and your doctor comply with the law regarding controlled pharmaceuticals. I understand that this Agreement is essential to the trust and confidence necessary in a doctor/patient relationship and that my doctor undertakes to treat me based on this Agreement. I understand that if I break this Agreement, my doctor may stop prescribing these pain- control medicines and may terminate me from the Graves Gilbert Clinic. I will communicate fully with my doctor about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve the pain.

Female Only- I certify that I am not pregnant. I agree and understand that it is my responsibility to notify my doctor if I believe I may be pregnant. I agree not to take any medication without approval if I become pregnant.

I will not use any illegal controlled substances (including marijuana, cocaine, heroin or other illegal substances.)

I will not share, sell, or trade my medication with anyone, I will bring all unused pain medicine to every visit.

I will not attempt to obtain any controlled medicines, stimulants, or anti-anxiety medicine from anyone else.

I will safeguard my medicine. NO allowance will be made for lost or stolen medicine/prescriptions.

I agree that refills of my prescriptions for pain medicine will be made only during regular office hour. No refills will be available during evenings or on weekends. Refill request may take up to 36 hours to complete.

I agree to use ONLY the following pharmacy for filling prescriptions of all my controlled medicines:

____

Print Pharmacy Name Address Phone

I authorize the doctor and my pharmacy to cooperate with any city, state, or federal law enforcement agency, or Board of Pharmacy, in the investigation of any possible misuse, sale or other diversion of my pain medicine. I authorize my doctor to provide a copy of this Agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations. I agree that I will submit a random drug test, at my expense. To determine my compliance with my program. I agree to enter a drug treatment program if my physician recommends it.

I agree that I will use my medicine at a rate no greater than the prescribed rate and that use of my medicine in a greater rate that may result in death and will result in my being without medications for a period of time.

I agree to follow this and other advice given by my healthcare provider or pharmacist. If the medication prescribed causes an adverse reaction, I will discontinue the medication immediately and notify my doctor.

I agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered. A copy of this document had been given to me.

This agreement is entered into on this ______day of _______________, 20_______

Patient Name (printed)__________________________Signature______________________________

Physician Signature _____________________________Witnessed By___________________________

Department of Family Medicine/ Sports Medicine

FA

PATIENT NAME:____________________________

PATIENT DATE OF BIRTH:______________________

Dear Patient;

In order to help us stay within the guidelines of HIPPA, please list any person/persons below that you authorize our office to disclose information to regarding your protected health information. We will <u>not</u> be able to disclose any of your personal health information or appointment information to anyone other than those listed below. **<u>(You do not need to list any of your doctors, worker's compensation carrier, auto insurance company, or lawyers' office.)</u>**

	Name	Relationship
1.	____________________	____________________
2.	____________________	____________________
3.	____________________	____________________
4.	____________________	____________________
5.	____________________	____________________

Do we have your permission to leave information from our office on your answering machine/voicemail when you are unable to answer the phone?

Yes No

____________________________ ____________________________

Patient (or Guardian) Signature **Today's Date**

FA

Name____________________

Date of Birth______________

Consent to Prescribe

Graves Gilbert Clinic and its physicians and nurse practitioners are authorized to provide me with prescriptions that using their independent judgement believes will benefit me. This includes prescriptions for drugs that are listed as controlled substances and have potentially harmful side effects and may be habit forming.

________________________________ ________________

Patient or Guardian Signature Date

____

Print Patient Name