# CALHOUN LIBERTY HOSPITAL PRIMARY CARE CLINIC
## NEW PATIENT APPLICATION

**Jared Barber, MD**
**Teressa Edenfield, APRN * Laura Ford, APRN* Hannah Causseaux, APRN**

**INCOMPLETE APPLICATIONS WILL NOT BE CONSIDERED**

Date of Application: ______________________

**You are applying to become a patient of The Practice and may see ANY provider as needs and scheduling apply.**

Patient Name: ____________________________________________________________________________

Date of Birth: ______/________/________ Social Security #: _______-_________-________

Mailing Address: __________________________________________________

__________________________________________________

Email Address: ____________________________________________________

Home Phone: ________________________

Cell Phone: __________________________

Physician you are now seeing: ______________________________________________

Reason(s) for changing physician: _____________________________________________________

Emergency contact name: _____________________________________________________

Emergency contact phone #: _______________________ Relationship to you: ___________________________

Emergency contact name: _____________________________________________________

Emergency contact phone #: _______________________ Relationship to you: ___________________________

***We accept: Medicare, Medicaid, Blue Cross Blue Shield, Capital Health Plan and most other major insurances. If you have been assigned to this practice by your insurance company you will still be required to complete the application and wait for it to be processed before an appointment can be made.

Primary insurance: ______________________________ Policy/ID#: _________________________________

Secondary insurance: ____________________________ Policy/ID#: _________________________________

**List all other household members.** Individual applications are required for EACH person applying to The Clinic.

| Name | Relationship to you | Physician | Name | Relationship to you | Physician |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |

Calhoun Liberty Hospital Primary Care Clinic
20370 NE Burns Ave
Blountstown, FL 32424
Phone: 850-237-3000 Fax: 850-237-3001

# Health History Intake Form

Do you have a Living Will? ☐ Yes ☐ No Today's Date: ________________________

Patient's Name: ___________________________________________________

Date of Birth: ______________________ Age: _______ Gender: ☐ Male ☐ Female

Previous Primary Care Physician (if any): ____________________________________
Phone: __________________ Address: _______________________________________________

Other Physician's involved in your care: _____________________________________________
_____________________________________________________________________________

Reason for visit today: _________________________________________________________
_____________________________________________________________________________

**Allergies-** (Medication/Food, indicate reaction): ☐ None

_____________________________________ _____________________________________
_____________________________________ _____________________________________
_____________________________________ _____________________________________
_____________________________________ _____________________________________
_____________________________________ _____________________________________

**Pharmacy:** _____________________________________ Phone:______________________

**Medication List:** (Please list name/dose/frequency if known)

_____________________________________ __________________________________
_____________________________________ __________________________________
_____________________________________ __________________________________
_____________________________________ __________________________________
_____________________________________ __________________________________
_____________________________________ __________________________________
_____________________________________ __________________________________
_____________________________________ __________________________________



Patient Name: _____________________________________________ DOB: ________________

**Past Medical History:**

| | | | |
|---|---|---|---|
| Headaches | ☐ Yes | ☐ No | date: ______________ |
| Stroke | ☐ Yes | ☐ No | date: ______________ |
| Seizures | ☐ Yes | ☐ No | date: ______________ |
| Pneumonia | ☐ Yes | ☐ No | date: ______________ |
| Diabetes Type: _________ | ☐ Yes | ☐ No | date: ______________ |
| Thyroid Disease Type: _________ | ☐ Yes | ☐ No | date: ______________ |
| Glaucoma | ☐ Yes | ☐ No | date: ______________ |
| Macular Degeneration | ☐ Yes | ☐ No | date: ______________ |
| Hearing Loss | ☐ Yes | ☐ No | date: ______________ |
| High Blood Pressure | ☐ Yes | ☐ No | date: ______________ |
| Blood Clots | ☐ Yes | ☐ No | date: ______________ |
| ☐ Pulm Emboli (lung clots) | ☐ Yes | ☐ No | date: ______________ |
| ☐ DVT (leg clots) | ☐ Yes | ☐ No | date: ______________ |
| Heart Burn, Reflux | ☐ Yes | ☐ No | date: ______________ |
| Stomach Ulcers | ☐ Yes | ☐ No | date: ______________ |
| Heart Disease | ☐ Yes | ☐ No | date: ______________ |
| ☐ Coronary Disease | ☐ Yes | ☐ No | date: ______________ |
| ☐ MI/Heart Attacks | ☐ Yes | ☐ No | date: ______________ |
| ☐ Congestive Heart Failure | ☐ Yes | ☐ No | date: ______________ |
| ☐ Atrial Fibrillation | ☐ Yes | ☐ No | date: ______________ |
| ☐ Angina | ☐ Yes | ☐ No | date: ______________ |
| ☐ Valve Disorder | ☐ Yes | ☐ No | date: ______________ |
| High Cholesterol | ☐ Yes | ☐ No | date: ______________ |
| Gastrointestinal Bleeding | ☐ Yes | ☐ No | date: ______________ |
| Hepatitis ☐A ☐B ☐C | ☐ Yes | ☐ No | date: ______________ |
| HIV/AIDS | ☐ Yes | ☐ No | date: ______________ |
| Chronic Wounds | ☐ Yes | ☐ No | date: ______________ |
| Cancer Type: _________ | ☐ Yes | ☐ No | date: ______________ |
| Urinary Tract Infections | ☐ Yes | ☐ No | date: ______________ |
| Incontinence | ☐ Yes | ☐ No | date: ______________ |
| Kidney Stones | ☐ Yes | ☐ No | date: ______________ |
| COPD (Emphysema, Bronchitis) | ☐ Yes | ☐ No | date: ______________ |
| Asthma | ☐ Yes | ☐ No | date: ______________ |
| Depression | ☐ Yes | ☐ No | date: ______________ |
| Bipolar Disorder | ☐ Yes | ☐ No | date: ______________ |
| Anxiety | ☐ Yes | ☐ No | date: ______________ |
| Fibromyalgia | ☐ Yes | ☐ No | date: ______________ |
| Chronic Fatigue Syndrome | ☐ Yes | ☐ No | date: ______________ |
| Arthritis | ☐ Yes | ☐ No | date: ______________ |
| Gout | ☐ Yes | ☐ No | date: ______________ |
| Osteoporosis | ☐ Yes | ☐ No | date: ______________ |
| Prostate Disease | ☐ Yes | ☐ No | date: ______________ |
| Breast Disease | ☐ Yes | ☐ No | date: ______________ |
| Erectile Dysfunction | ☐ Yes | ☐ No | date: ______________ |

Other: ________________________________________________

**Hospitalizations**

________________________________________
________________________________________
________________________________________
________________________________________

**Immunizations History**

Tetanus date: _________
Flu date: _________
Pneumonia 23 or 13 date: _________



Patient Name: ______________________________ DOB: ______________

**Past Surgical History (indicate date if known)**

☐ None
☐ Cataracts _______________
☐ Lasik _______________
☐ Tonsillectomy _______________
☐ Thyroidectomy _______________
☐ Adenoidectomy _______________
☐ Coronary Bypass _______________
☐ Cardiac Stents _______________
☐ Pacemaker _______________
☐ Heart Valve _______________
☐ Gall Bladder _______________
☐ Appendectomy _______________
☐ Hemorrhoidectomy _______________
☐ Bariatric Surgery _______________
☐ Hysterectomy _______________
☐ Endoscopy _______________
☐ Colonoscopy _______________
☐ Hernia _______________
☐ Spinal Surgery _______________
☐ Tubal Ligation _______________
☐ Bladder Surgery _______________
☐ Prostate surgery/resection _______________
☐ C-Section _______________
☐ Orthopedic/joints _______________
☐ Bowel/Stomach Resection _______________
☐ Other _______________

**List of past health conditions:** (If not mentioned above)

_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________

**Physical History**

Annual Physical ☐ Yes ☐ No date: __________ Physician: ____________
Mammogram ☐ Yes ☐ No date: __________ Facility: ______________
Bone Density Scan (Dexa) ☐ Yes ☐ No date: __________ Facility: ______________

**Family History:** (please indicate deceased or alive, medical issues and age)

Father: ____________________________________________________________
Mother: ____________________________________________________________
Siblings: ____________________________________________________________
Grandparents: ________________________________________________________

**Social History:**

Work: ☐ Employed ☐ Unemployed ☐ Retired ☐ Disabled
Current Occupation____________________________ Former Occupation _________________________
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Domestic Partner
Sexual Preference: ☐ Men ☐ Women ☐ Both
Children (age): ______________________________________________________
Hobbies: ____________________________________________________________
Sports: _____________________________________________________________
Pets: _______________________________________________________________
Other: ______________________________________________________________

**Habits:**

Alcohol: ☐ None ☐ Yes: How many drinks/day _________ frequency/week _________ what kind ______
Tobacco: ☐ None ☐ Yes: Chew or Smoke? _________ How many/day __________ since _________
Caffeine: ☐ None ☐ Yes: What kind? _________________________ How many/day ____________
Other recreational drugs: ☐ None ☐ Yes: What kind __________________ How many/day ________
Do you drive? ☐ Yes ☐ No Do you always wear a seatbelt? ☐ Yes ☐ No
Do you exercise? ☐ Yes ☐ No If yes, how much? ______________________________



Patient Name: ____________________________________________ DOB: _________________

**Review of Systems ( ✓ Yes or No for symptoms in past 6 months, Circle for symptoms TODAY)**

**Constitutional/Endocrine**

- ☐ Yes ☐ No Fever
- ☐ Yes ☐ No Chills
- ☐ Yes ☐ No Weakness/Fatigue
- ☐ Yes ☐ No Weight Loss
- ☐ Yes ☐ No Weight Gain
- ☐ Yes ☐ No Insomnia
- ☐ Yes ☐ No Snoring
- ☐ Yes ☐ No Excessive thirst
- ☐ Yes ☐ No Excessive urination
- ☐ Yes ☐ No Cold or Heat intolerance

**HEENT**

- ☐ Yes ☐ No Sore Throat
- ☐ Yes ☐ No Stiff neck
- ☐ Yes ☐ No Change in your voice
- ☐ Yes ☐ No Sinus Drainage
- ☐ Yes ☐ No Sinus headache
- ☐ Yes ☐ No Nose Bleeds
- ☐ Yes ☐ No Ear ache/drainage
- ☐ Yes ☐ No Hearing Loss
- ☐ Yes ☐ No ringing in your ears
- ☐ Yes ☐ No Blurred Vision/loss
- ☐ Yes ☐ No Wear glasses/contacts
- ☐ Yes ☐ No Itchy/watery eyes
- ☐ Yes ☐ No Dental problems

Other: ________________

**Gastrointestional**

- ☐ Yes ☐ No Nausea/vomiting
- ☐ Yes ☐ No Difficulty swallowing
- ☐ Yes ☐ No Hemorrhoids
- ☐ Yes ☐ No Diarrhea
- ☐ Yes ☐ No Constipation
- ☐ Yes ☐ No Bloody or Black Stools
- ☐ Yes ☐ No Abdominal pain
- ☐ Yes ☐ No Heart burn/indigestion
- ☐ Yes ☐ No Frequent use of laxatives

Other: ________________

**Urinary**

- ☐ Yes ☐ No Pain or burning with urination
- ☐ Yes ☐ No Urinary frequency (Night or Day)
- ☐ Yes ☐ No Blood in urine/ dark urine
- ☐ Yes ☐ No Incontinence
- ☐ Yes ☐ No Slow starting or stopping urine

Other: ________________

**Genital/Sex Organs**

- ☐ Yes ☐ No Penile Discharge
- ☐ Yes ☐ No Testicular lump/pain
- ☐ Yes ☐ No Breast Pain/discharge/Lump
- ☐ Yes ☐ No Painful intercourse
- ☐ Yes ☐ No Lack of sexual desire
- ☐ Yes ☐ No Problems with performance

Other: ________________

**Musculoskeletal**

- ☐ Yes ☐ No Joint pains/stiffness
- ☐ Yes ☐ No joint swelling
- ☐ Yes ☐ No Muscle weakness
- ☐ Yes ☐ No Back pain
- ☐ Yes ☐ No Muscle spasms/cramps
- ☐ Yes ☐ No falling

Other: ________________

**FEMALE Reproductive**

- ☐ Yes ☐ No Hot flashes
- ☐ Yes ☐ No Bleeding after menopause
- ☐ Yes ☐ No Excessive menstrual bleeding
- ☐ Yes ☐ No Unusual vaginal discharge

Age at onset of menstruation _____________

1st day of last menstruation ______________

- ☐ Yes ☐ No Menstrual pain/cramps
- ☐ Yes ☐ No Spotting between periods

Last PAP smear: ______________Results:___________

History of Abnormal PAP? ☐ Yes ☐ No if so, when ________

Total Pregnancies: _____________________

**Cardiac**

- ☐ Yes ☐ No Chest Pain
- ☐ Yes ☐ No Palpitation
- ☐ Yes ☐ No Irregular heartbeat
- ☐ Yes ☐ No Exercise intolerance
- ☐ Yes ☐ No Leg Swelling

Other: ________________

**Respiratory**

- ☐ Yes ☐ No Persistent Cough
- ☐ Yes ☐ No Coughing up blood
- ☐ Yes ☐ No Wheezing
- ☐ Yes ☐ No Can't breathe laying flat

Other: ________________

**Skin**

- ☐ Yes ☐ No Rashes/Hives
- ☐ Yes ☐ No Skin discoloration
- ☐ Yes ☐ No Lesions/moles/warts
- ☐ Yes ☐ No Ulcers
- ☐ Yes ☐ No Itching
- ☐ Yes ☐ No Nail Problem
- ☐ Yes ☐ No Unusual hair loss
- ☐ Yes ☐ No easy bruising

Other: ________________

**Psych**

- ☐ Yes ☐ No Depressed mood
- ☐ Yes ☐ No Suicidal thoughts/plans
- ☐ Yes ☐ No Agitation/Irritability
- ☐ Yes ☐ No Insomnia
- ☐ Yes ☐ No Anxiety
- ☐ Yes ☐ No Frequent crying spells

Other: ________________

**Neurologic**

- ☐ Yes ☐ No Frequent headaches
- ☐ Yes ☐ No Seizures
- ☐ Yes ☐ No Syncope (passing out)
- ☐ Yes ☐ No Limb weakness
- ☐ Yes ☐ No Limb numbness
- ☐ Yes ☐ No Dizziness
- ☐ Yes ☐ No Difficulty Swallowing
- ☐ Yes ☐ No Balance issues
- ☐ Yes ☐ No Tremors
- ☐ Yes ☐ No Rigidity
- ☐ Yes ☐ No History of Falls

Other: ________________