DURANT FAMILY MEDICINE CLINIC HEALTH QUESTIONNAIRE

Name: Date: Birthday: Chart #

Reason For Visit

List All Medications You Are Taking Now	**DRUG Allergies**	
Medication Name *include Over the Counter*	Strength	How Often Do You Take This Medication

Medical History ***Mark "C" for current problems, check and indicate date when you had any of the following symptoms or diseases.***

	ADHD	Alcohol drinks per week
	ALLERGIC RHINITIS	Tobacco cig/day #years
	ANEMIA	year quit
	ANXIETY	Second Hand Smoke Exposure No Yes
	ARTHRITIS	Caffeine (Coffee /Tea/Soda) Cups per day
	ASTHMA	Illicit Drugs No Yes - Please list
	BACK PAIN CHRONIC LOW	Do you exercise regularly No Yes
	BOWEL CHANGES/CONSTIPATION/DIARRHEA	Sexually Active No Yes
	CANCER - what kind?	**FEMALES - PLEASE COMPLETE THE FOLLOWING:**
	COPD	Pain / Bleeding during or after sex No Yes
	DEPRESSION	Menstrual Flow:
	DIABETES	Regular Irregular Painful Cramps
	DIVERTICULOSIS	Days of Flow Length of Cycle
	GERD	Date - 1st day last period
	HEART DISEASE/CORONARY ARTERY DISEASE	Number of: Pregnancies Live Births
	HEPATITIS	Miscarriages Abortions
	HIGH BLOOD PRESSURE	Birth Control method
	HIGH CHOLESTEROL	Birth Control pill name
	HYPOTHYROIDISM	Hot Flashes NO YES
	OBESITY	Date of last PAP test
	SEIZURE	Normal Abnormal
	DIFFICULTY WITH URINATION	Date of last Mammogram
	OTHER:	Normal Abnormal

Hospital Admissions	Year	HOSPITALIZATION	Year	SURGERY
Not Including Pregnancies				

Family History

FATHER [ ] Diabetes [ ]High Blood Pressure [ ]Heart Disease [ ]Cancer [ ]Stroke [ ]Mental Illness [ ]Other______________________________

Father - Year of Birth_________________ [ ] Alive [ ] Deceased

MOTHER [ ] Diabetes [ ]High Blood Pressure [ ]Heart Disease [ ]Cancer [ ]Stroke [ ]Mental Illness [ ]Other______________________________

Mother - Year of Birth _________________ [ ] Alive [ ] Deceased

RESPONSIBLE PARTY/GUARDIAN SIGNATURE **DOCTOR SIGNATURE**

DURANT FAMILY MEDICINE CLINIC

1600 W UNIVERSITY BLVD   DURANT, OK 74701   PHONE 580.924.5500   FAX 580.924.1991

DEMOGRAPHICS FOR RETURNING PATIENT

DATE_____/_____/_____

PATIENT NAME____
LAST **FIRST** **MIDDLE** **(MAIDEN NAME IF MARRIED)**

MAILING ADDRESS____City_____________________State___________Zip__________

Home Phone (_____) _________-____________Cell Phone (_____) _________-___________Work Phone (_____) ________-__________

DATE OF BIRTH_____/_____/_____   ☐Single   ☐Married   ☐Divorced   ☐Widowed   ☐Separated

SSN______-______-_________   **[ ]** Retired   **[ ]** Disabled   Occupation____

Employer____   Full Time   Part Time   Temporary

Employer Address____City_________________State______________Zip_________

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Preferred Pharmacy:____

RELEASE OF INFORMATION: Information regarding treatment of a minor may only be released after signature of the legal guardian(s). I hereby authorize the release of any information necessary to process insurance claims for services rendered by DURANT FAMILY MEDICINE CLINIC. I hereby authorize DURANT FAMILY MEDICINE CLINIC to release any and all medical information to previous and future physicians involved in my care. If you email our office with a medical question or information you are giving implied consent for information to be transmitted electronically. Our office must have written permission to release information regarding your care to any other person, including but not limited to a spouse, parent, sibling, etc. A valid HIPAA authorization to release protected health information is required prior to release

PLEASE INITIAL_______

I have reviewed Durant Family Medicine Clinic's Notice of Privacy Practices which explains how my medical information will be used and disclosed. I understand I am entitled to receive a copy of this document which is posted in the lobby/waiting room. The information contained on this demographics form is true and correct.

I acknowledge my original signed Principles of Medical Home which details an agreement between myself the assigned physician of my care at Durant Family Medicine Clinic.

I acknowledge my original signed Payment Policy.

I acknowledge my original signed Medication Contract is still valid.

Any of the above policies previously signed are available for my review upon request.

____   _______-______-_______

Signature of Patient /Legal Guardian   **Date**

DURANT FAMILY MEDICINE CLINIC
1600 W UNIVERSITY BLVD DURANT OK 74701 PHONE 580.924.5500 FAX 580.924.1991

Patient Name______________________DOB___/__/____MR#___________________

Contact me at **[ ]** Home Phone **[ ]** Cell Phone **[ ]** Work Phone

DFMC may **[ ]** leave a detailed message **[ ]** leave a call back number only

Other info____

DFMC uses automated appointment reminders. Please tell us you're the preferred time for receiving your reminder which is sent approximately 1-2 days before your appointment.

[ ] Morning **[ ]** Afternoon **[ ]** Evening

Email____[ ] No Email

I authorize the following person(s) to obtain or provide information regarding my

_______________________________Relationship________Phone____________________
[ ] Appointment(s) [ ] Emergency Contact [ ] Health [ ] Financial / Insurance information:

_______________________________Relationship________Phone____________________
[ ] Appointment(s) [ ] Emergency Contact [ ] Health [ ] Financial / Insurance information:

_______________________________Relationship________Phone____________________
[ ] Appointment(s) [ ] Emergency Contact [ ] Health [ ] Financial / Insurance information:

_______________________________Relationship________Phone____________________
[ ] Appointment(s) [ ] Emergency Contact [ ] Health [ ] Financial / Insurance information:

DFMC is unable to provide any information to anyone not listed above due to HIPAA Privacy Laws.

I have an Advance Directive regarding healthcare issues **[ ]** No **[ ]** Yes – Please provide a copy to DFMC

I have reviewed Durant Family Medicine Clinic's Notice of Privacy Practices which explains how my medical information will be used and disclosed. I understand I am entitled to receive a copy of this document which is posted to the right of the check-in window. The information contained on this demographics form is true and correct.

____ ________/_________/_________
Signature of Patient /Legal Guardian if Patient is a Minor **Date**

Durant Family Medicine Clinic

1600 W University Blvd Durant OK 74701
Phone 580.924.5500 Fax 580.924.1991

MEDICATION CONTRACT

All medications prescribed by a Durant Family Medicine Clinic physician after the date of this contract are included herein and made a part of this Medication Contract.

1. I acknowledge and consent to treatment with non-narcotic, narcotic, opioid or controlled substances. I understand that these medications were prescribed to me because I state that I have a serious condition. I am aware of risks associated with these meds that may include drowsiness, constipation, slowing of reflexes. I know that I should not drive or participate in any activity requiring mental alertness or physical coordination when I take narcotic, opioid or controlled substance medication(s). Further, I know that the use of these medications can lead to tolerance, physical dependence or addiction.
2. I agree to take my medication(s) as prescribed and directed by my DFMC physician.
3. I acknowledge and understand that I will need regular appointments to continue this treatment. Prescriptions will only be refilled at the time of the appointment and never over the phone. I will call the office for an appointment one (1) week before I run out of my medication.
4. I acknowledge and understand that I cannot obtain these or similar medications from a source other than Durant Family Medicine Clinic. I acknowledge and understand that doing this will result in no further similar prescriptions given for this problem from Durant Family Medicine Clinic.
5. I acknowledge and understand that Durant Family Medicine Clinic will not refill medications that have been lost, stolen, misplaced or damaged.
6. I agree not to share, give or sell my medication to any other person and I am aware that this constitutes a criminal act.
7. I acknowledge and understand that I cannot use alcohol or any street drugs with my medication.
8. I acknowledge and understand that if I am receiving medication or am the parent of a child receiving medication, I agree to random drug screening at any time at my own expense, including today. If I am called for a random drug test I agree to present to the office within 3 hours for drug screening. Failure to appear and provide valid urine for testing with be considered a violation of this contract. I understand that if I fail to show up for a medical management appointment it is grounds for termination from DFMC.
9. I agree to release this contract information to Alliance Health Durant Hospital and to pharmacies in Bryan and surrounding counties.
10. I consent to all pharmacies communicating with Durant Family Medicine Clinic with regard to my use of controlled and non-controlled substances and the providers of those substances.
11. I understand that a state and/or nationwide database will be accessed to find all medications I have been prescribed by all medical providers.
12. I understand that I must request a refill for all non-narcotic routine medications five (5) days before I will be out of the medication by calling my pharmacy. Routine medications for chronic disease(s) require an office visit every 3-6 months and may not be refilled if I do not see my physician on a routine basis.
13. I acknowledge and understand that violation of this contract is grounds for termination from Durant Family Medicine Clinic.
14. If I violate any tenet of this contract, I acknowledge and understand that this contract is broken and my medication will no longer be prescribed.

Print Name of Patient____

____ _____/_____/_____
Signature of Patient or Parent/Legal Guardian if under 18 **Date**