DURANT FAMILY MEDICINE CLINIC HEALTH QUESTIONNAIRE

Name: Date: Birthday: Chart #

Reason For Visit

HAVE YOU BEEN OUT OF THE UNITED STATES ___**No** ____ **Yes-Date**__________**Where**________________________

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	**MEDICAL MARIJUANA CARD _____NO _____YES**
	BOWEL CHANGES/CONSTIPATION/DIARRHEA	Do you exercise regularly ____No ____Yes
	CANCER - what kind?	Sexually Active No Yes
	COPD	**FEMALES - PLEASE COMPLETE THE FOLLOWING:**
	DEPRESSION	Pain / Bleeding during or after sex No Yes
	DIABETES	Menstrual Flow:
	DIVERTICULOSIS	Regular Irregular Painful Cramps
	GERD	Days of Flow Length of Cycle
	HEART PROBLEMS:]	Date - 1st day last period
	HEPATITIS	Number of: Pregnancies Live Births
	HIGH BLOOD PRESSURE	Miscarriages Abortions
	HIGH CHOLESTEROL	Birth Control method
	HYPOTHYROIDISM	Birth Control pill name
	OBESITY	Hot Flashes NO YES
	SEIZURE	Date of last PAP test
	DIFFICULTY WITH URINATION	Normal Abnormal
	COVID-19 Date:	Date of last Mammogram
	OTHER:	Normal Abnormal

Hospital Admissions Not Including Pregnancies	Year	HOSPITALIZATION	Year	SURGERY

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

SIGN HERE ->

RESPONSIBLE PARTY/GUARDIAN SIGNATURE **DOCTOR SIGNATURE**

Name: Date: Date of Birth:

Medications prescribed by Doctors	Strength	How Often Do You Take This Medication
MEDICINE YOU TAKE NOT PRESCRIBED BY A DOCTOR	**STRENGTH**	**HOW OFTEN DO YOU TAKE THIS MEDICATION**
If you have a Medical Marijuana Card please describe how you use the marijuana (smoke, eat gummies, and how much you use each day)		
LIST ALL YOUR ALLERGIES		
COVID VACCINE YES NO	**DATE OF LAST VACCINE:**	

Patient____

Alcohol Use Screening Audit C

Did you have a drink containing alcohol in the past year?

____Yes
____ No

If Yes: How often did you have a drink containing alcohol in the past year?

_____ Never
_____ Monthly or less
_____ Two to four times in a month
_____Two to three times per week
_____Four or more times a week

If Yes: How many drinks did you have on a typical day when you were drinking in the past year?

_____ 1 or 2 _____ 3 or 4 _____ 5 or 6 _____7-9 _____10 or more

If Yes: How often did you have six or more drinks on one occasion in the past year?

_____Never _____Less than monthly _____Monthly _____Weekly _____Daily

Depression Screening PHQ2

Please indicate the answer that best describes you during the past two weeks:

Do you have little interest or pleasure in doing things?

_____Not at all
_____ Several Days
_____More than half the days
_____ Nearly every day
_____ Decline to Specify

Feeling down, depressed or hopeless?

_____Not at all
_____ Several Days
_____More than half the days
_____ Nearly every day
_____ Decline to Specify

Tobacco Control

___Non Smoker

___Chews Tobacco

___Former Smoker **YOU MAY STOP HERE IF YOU DO NOT CURRENTLY SMOKE.**

___Current Smoker ___everyday ___some days, but not every day

___5 or less ___6-10 ___11-20 ___21-30 ___31 or more

After you wake up when do you smoke your first cigarette ___5 min ___6-30min ___31-60min ___after 60

Are you interested in quitting? ___Ready to quit ___Thinking about quitting ___Not ready to quit

Sexual History

Have you had sex in the last 12 months? (vaginal, oral or anal)? _____Yes _____No

With _____Men Only _____Women Only _____With Both Men & Women

Do you use protection? _____Yes _____No

Type of Birth Control: ____

Have you ever had an STD or STI? _____Yes _____No

Chlamydia? _____Yes _____No

Gonorrhea? _____Yes _____No

Syphilis? _____Yes _____No

Herpes? _____Yes _____No

Other? _____Yes _____No

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__________

EMAIL ADDRESS ____

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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

I acknowledge the person originally listed on my initial visit is authorized to obtain or provide information regarding my appointments, emergency contact, health and financial/insurance information.

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.

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

I acknowledge my original signed Payment Policy.

I acknowledge my original signed Medication Contract and/or Patient-Physician Agreement is still valid.

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

Date

____ ________-______-_______

Signature of Patient /Legal Guardian

Patient Name_________________________________DOB___/____/____MR#_________________

DFMC uses **automated calls/texts/emails** for appointments, lab results and general notifications like flu shot reminders, etc. Please tell us the preferred time and method you prefer for the following:

Preferred time to receive notification Morning ☐ Afternoon ☐ Evening ☐

Preferred phone number for texts____________________and/or voice mail_________________________

Email ____ [ ] No Email

Preferred Method of Contact

How should the staff or doctor contact you:

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

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

Other info____

I authorize the following person(s) to obtain or provide information regarding my appointments, emergency contact, health and financial/insurance information: Please provide at least 2 contacts.

____Relationship_________Phone__________________

____Relationship_________Phone__________________

____Relationship_________Phone__________________

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. If this information changes I acknowledge it is my responsibility to update this information with Durant Family Medicine Clinic.

____ ________/_________/_________

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**