

Patient Name: _____

PATIENT'S PERSONAL HISTORY

DOB _____ Today's Date _____

Confidential Record: Information contained here will not be released except when you have authorized us to do so.
.....

Address: _____ City _____ State _____ Zip _____

Phone # _____ Sex: M F Social Security # _____

Employer _____ Work or Cell # _____

Primary Insurance _____ Ins. # _____

Secondary Insurance _____ Ins. # _____

Previous Physician of Referring Physician _____
(Bring Insurance Cards, Medications, Medical Records, and New Patient Forms with you to your appointment)

Marital Status _____ Spouse's Name _____ Social Sec # _____

Spouse employer _____ Work # _____ Religion _____

.....

Late Cancellation Policy: Patients are responsible for canceling all scheduled appointments within 24 hours. Failure to keep an appointment without giving at least 24 hours notice will generate a charge of \$25.00 to the patient's account. The patient is responsible for this charge, which is non-billable to the insurance company.

Signature of Responsible Party _____ Date _____
.....

Person to notify in an Emergency
(Not living in your household) _____

Relationship _____ Phone # _____
.....

Responsible Party: _____ Relationship to Patient _____

I hereby authorize Cullman Internal Medicine P.C. to furnish to the above insurance company(s) all information, which said insurance company, may request. I hereby assign to Cullman Internal Medicine P.C., all money to which I am entitled for medical/surgical expense relative to the service rendered but not to exceed my indebtedness to the professional corporation. I understand that I am financially responsible to the said corporation for charges not covered by this assignment. I further agree, in the event of nonpayment, to bear the cost of collection and/or court cost and responsible legal fees, should this be required.

Patient Signature: _____

Parent/Guardian Signature: _____

PATIENT'S FAMILY HISTORY

IF LIVING

IF DECEASED

Father: Age _____ Health _____ Age at Death _____ Cause _____
Mother: Age _____ Health _____ Age at Death _____ Cause _____

Siblings:

Name: _____ Sex: M F
Age: _____ Health _____ Age at Death _____ Cause _____

Name: _____ Sex: M F
Age: _____ Health _____ Age at Death _____ Cause _____

Name: _____ Sex: M F
Age: _____ Health _____ Age at Death _____ Cause _____

Name: _____ Sex: M F
Age: _____ Health _____ Age at Death _____ Cause _____

Your children

Name: _____ Sex: M F
Age: _____ Health _____ Age at Death _____ Cause _____

Name: _____ Sex: M F
Age: _____ Health _____ Age at Death _____ Cause _____

Name: _____ Sex: M F
Age: _____ Health _____ Age at Death _____ Cause _____

Name: _____ Sex: M F
Age: _____ Health _____ Age at Death _____ Cause _____

Do you know of any blood relative who has or had (circle and give relationship)

Stroke _____ Epilepsy _____ Heart Attack _____

Suicide _____ Cancer _____

High Blood Pressure _____ Asthma _____

Nervous Breakdown _____ Migraines _____

Stomach Ulcers _____ Kidney Disease _____ Rheumatic Fever _____

TB _____ Hay Fever _____ Goiter _____

Insanity _____ Leukemia _____ Diabetes _____

Arthritis _____ Bleeding Tendency _____

Congenital Heart Disorder _____ Colitis _____

PERSONAL HABITS (Circle)

Yes No Do you regularly smoke? Cigarettes Pipe Cigars How many years? _____

Yes No Do you usually drink over six (6) cups of coffee per day?

Yes No Do you regularly drink alcohol? 1 oz per day 2 oz per day 4 oz per day over 6 oz per day
BEER 1 bottle per day 2 bottles per day over 4 bottles per day
WINE 1 glass per day 2 glasses per day over 4 glasses per day

Yes No Do you have difficulty falling asleep?

Yes No Do you awaken early in the morning without apparent cause?

SURGICAL HISTORY

What operations have you had? _____

ALLERGIES

Name any drug you are allergic to and what type reaction each drug causes _____

MEDICAL HISTORY

Write the names of any illnesses that have required hospitalization _____

Write the names of any serious illnesses you've had that that did NOT require hospitalization _____

List any serious injuries or accidents _____

Yes	No	Have you ever fainted?	Yes	No	Have you ever had a convulsion?
Yes	No	Spells of dizziness?	Yes	No	Double Vision?
Yes	No	Spells of weakness of arm/leg?	Yes	No	Pain in ear?
Yes	No	Ringing in the ears?	Yes	No	Nosebleeds?
Yes	No	Do you frequently have bleeding gums?	Yes	No	Do you frequently have a sore tongue?
Yes	No	Do you frequently have trouble swallowing?	Yes	No	Do you frequently have hoarseness?
Yes	No	Do you frequently have nausea and vomiting?			

Have you ever had shortness of breath:

Yes	No	Doing your usual work?	Yes	No	Which causes you to cough?
Yes	No	Climbing a flight of stairs?	Yes	No	Accompanied by wheezing?
Yes	No	Which awakens you at night?	Yes	No	Have you ever coughed up blood?
Yes	No	Do you have a chronic cough?	Yes	No	Do you cough up sputum?

Have you ever had chest pain or tightness:

Yes	No	When you exert yourself?	Yes	No	Which radiates down the arm?
Yes	No	When walking against the wind?	Yes	No	Which disappears if you rest?
Yes	No	When walking up a hill?	Yes	No	Which occurs only at rest?
Yes	No	After a heavy meal?	Yes	No	When walking fast?
Yes	No	When upset or excited?	Yes	No	When walking in cold weather?
Yes	No	Do you sleep on more than one pillow?	Yes	No	With Palpitations?

If you have chest pain or tightness please describe _____

Have you recently had pain in the stomach which:

Yes	No	Occurs 1-2 hours after meals?	Yes	No	Awakens you at night?
Yes	No	Is brought on by eating fried food?	Yes	No	Is relieved by antacids?
Yes	No	Occurs while eating or immediately after?	Yes	No	Is relieved by a bowel movement?
Yes	No	Is relieved with milk or eating?	Yes	No	Causes loss of appetite?

If you had a change in bowel habits recently answer the following:

- | | | | | | |
|-----|----|--------------------------------------|-----|----|---------------------|
| Yes | No | Crampy pain in abdomen? | Yes | No | Blood in stool? |
| Yes | No | Alternating diarrhea & constipation? | Yes | No | Ribbon-like stools? |
| Yes | No | Pain during or after bowel movement? | Yes | No | Black stools? |
| Yes | No | Require use of laxative or enema? | Yes | No | Mucous in stool? |

Have you had:

- | | | | | | |
|-----|----|------------------------------|-----|----|-----------------------------|
| Yes | No | Burning when urinating? | Yes | No | Loss of control of bladder? |
| Yes | No | Blood in urine? | Yes | No | Dark colored urine? |
| Yes | No | Trouble starting to urinate? | Yes | No | Trouble holding urine? |
| Yes | No | Frequent night urination? | Yes | No | A kidney stone? |

Have you recently had:

- | | | | | | |
|-----|----|--------------------------------------|-----|----|--------------------------|
| Yes | No | Pain in calves of legs when walking? | Yes | No | Cramps in legs at night? |
| Yes | No | Pain in the big toe? | Yes | No | Varicose veins? |
| Yes | No | Phlebitis or inflamed leg veins? | Yes | No | Swelling in the ankles? |

Do you frequently have severe headaches? If yes, please answer the following

- | | | | | | |
|-----|----|---|-----|----|---------------------------------|
| Yes | No | Do they cause visual trouble? | Yes | No | Do they occur on one side? |
| Yes | No | Do they awaken you from sleep? | Yes | No | Do they feel like a tight band? |
| Yes | No | Do they hurt most in the back of the head/neck? | | | |
| Yes | No | Are they relieved by aspirin? | | | |

TO BE ANSWERED BY WOMEN ONLY

- | | | | | |
|-----|----|---|-------------------|-------|
| Yes | No | Are you still having regular monthly menstrual periods? | When? | _____ |
| Yes | No | Have you ever had bleeding between your periods? | When? | _____ |
| Yes | No | Do you have very heavy bleeding with your periods? | | |
| Yes | No | Do you feel bloated and irritable before your periods? | | |
| Yes | No | Are you now on or have you ever taken birth control pills? | When? | _____ |
| Yes | No | Have you ever had a miscarriage? | When? | _____ |
| Yes | No | Have you ever had discharge from the nipple of your breast? | When? | _____ |
| Yes | No | Do you regularly have cancer test of the cervix? | Date of last test | _____ |

- How many children born alive? _____
- How many stillbirths? _____
- How many premature births? _____
- Date of last menstrual period _____

- How many miscarriages? _____
- How many C-sections? _____
- Any pregnancy complications? _____
- Name of OB/GYN _____

TO BE ANSWERED BY MEN ONLY

Have you ever had

- | | | | | | |
|-----|----|--|-------|----|---------------------------|
| Yes | No | Treatment for genitals? | Yes | No | Discharge from the penis? |
| Yes | No | Hernia (rupture)? | Yes | No | Prostate trouble? |
| Yes | No | Loss of sexual activity? For how long? | _____ | | |

Briefly describe your present medical symptoms:

Cullman Internal Medicine
1890 Alabama Highway 157, Suite 300
Cullman, Alabama 35058

William F. Peinhardt, M.D.
Phillip W. Freeman, M.D.
L. James Hoover, M.D.
W. Michael Hall, M.D.
NayKala Ruse, M.D.
Lisa Ellard, CRNP
Kelley Johnson, CRNP
Rebecca Harris, CRNP

George A. Lyrene, M.D.
John D. Morris, M.D.
C. Anthony Rutledge, M.D.
Gary. E. Holland, M.D.
Lane Friedman, M.D.
Bethany Lamar, CRNP
Anne Armstrong, CRNP
Paige McDonald, CRNP

STATEMENT TO PERMIT PAYMENT
OF MEDICARE BENEFITS TO RURAL HEALTH CLINIC
EXTENDED PATIENT SIGNATURE AUTHORIZATION

Name of Beneficiary

HI Claim Number

I request payment of authorized Medicare benefits on my behalf for any services furnished me by Cullman Internal Medicine, P.C. I authorize any holder of medical and other information about me to release to Medicare and its agents, any information needed to determine these benefits for related services.

Date

Patient Signature

Please be sure to sign the privacy compliance form and request for medical records forms that are included in your packet.

Please keep this paper as a reminder of the following numbers and call the number for your physician or nurse practitioner when you have a question, need to schedule an appointment or need a refill:

Dr. Hall, Dr. Lyrene, Bethany Lamar CRNP, Paige McDonald CRNP – **737-8050**

Dr. Naykala A. Ruse 737-8050

Dr. Peinhardt, Dr. Morris, Becky Harris CRNP, Lisa Ellard CNP – **737-8051**

Dr. Friedman, , Dr. Rutledge, Anne Armstrong CRNP – **737-8052**

Dr. Freeman, Dr. Hoover, Kelley Johnson CRNP – **737-8053**

Marcia Tillman CRNP 737-8053

If you have had lab drawn and have not received a letter within one (1) week, call the appropriate number listed above. **Please do not call before one week has passed.**

Questions concerning bills and/or insurance should be directed to PRN – **775-0432**

Two days before your appointment, you will receive an automated call reminding you of your appointment. It is not necessary to return this call unless you need to cancel or change your appointment. If so, please call the appropriate number listed above.

Please bring your insurance cards with you, also please bring all of your medication that you are taking.

Cullman Internal Medicine Medication List

Please list all of your current medications including the name of your medication, the dosage amount and the directions. Example – Nexium 40mg once per day.
Please do not include dietary supplements.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____
18. _____

