Gwendolyn J. Allen MD

Family Practice

1604 14th Street
Brownwood Texas 76801
(325)646-5296
www.GwenAllenMD.com

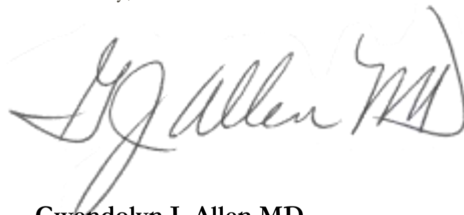
Welcome,

We are honored that you have chosen us to assist you to Better Family Health. Our goal is to provide the highest quality care for all of our patients in a timely and respectful atmosphere. We are different than other medical offices you may have visited. This is a private practice, it is not owned by a large healthcare entity or a large group of physicians. We practice medicine the way it should be practiced. We spend time with our patients.

We ask that you take note of the following:

- All co-pays and past due balances are expected at time of service.
- Please remember that each appointment is scheduled for ONE specific issue only which helps us to minimize your wait time.
- If you are 15 minutes late, your appointment will be rescheduled for another day.
- Bring all prescription bottles and over the counter supplements to appointments with a provider.
- Insurance Cards and ID are required at each office visit. This is for your protection.

Sincerely,



Gwendolyn J. Allen MD

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Family Practice

REGISTRATION FORM

Today's date:

PATIENT INFORMATION

Patient's Last name: First: Middle: | Marital status: ❑Single ❑Separated ❑ Married ❑Divorced ❑Widowed

Is this your legal name? ❑ Yes❑ No If not, what is your legal name? | (Former name): | Birth date: | Age: | Sex: ❑ M❑ F

check all that apply Race: ❑American Indian ❑Asian ❑African American ❑Hawaiian ❑Caucasian/White ❑Hispanic/Latino ❑Other:_______________ ❑Declined | Spoken Language: ❑ English ❑ Spanish ❑ Other:_______________

Email Address:

Street address: | Social Security no.: | Home phone no.:

P.O. Box: | City: | State: | ZIP Code:

Occupation: | Employer: | Employer phone no.:

How did you hear about us?

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill: | Birth date: | Address (if different): | Home phone no.:

Is this person a patient here? ❑ Yes ❑ No

Occupation: | Employer: | Employer address: | Employer phone no.:

Is this patient covered by insurance? ❑ Yes❑ No

Please indicate primary ins. ❑ BCBS ❑ Aetna ❑ Cigna ❑ Tricare ❑ Humana ❑ Medicare ❑ United Healthcare ❑ CHiP's ❑ Medicaid ❑ Other__________________

Subscriber's name: | Subscriber SS#.: | Birth date: | Group no.: | Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other (please specify): ____________________

Name of secondary insurance (if applicable): | Subscriber's name: | Group no.: | Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other (please specify): ____________________

IN CASE OF EMERGENCY

Relation	Name	Home	Cell	Work

The above information is true to the best of my knowledge. I hereby give Gwendolyn J. Allen MD PA and staff permission to examine and treat my medical condition(s). I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance on my account regardless of my insurance status. I also authorize Gwendolyn J. Allen MD PA or insurance company to release any information required to process my claims. I will notify this office of any changes in my personal or insurance information immediately.

Patient/Guardian signature *Date*

PATIENT AGREEMENT

Payment is due at time services are rendered. By signing and initializing below, you agree to and understand the following policies:

HIPAA- Privacy Notice

I am aware that I may review Gwendolyn J. Allen MD (GJAMD) HIPPA privacy notice at any time and understand that I may request a copy.

____
Initials

GJAMD Medical Care Agreement

I authorize the physicians of GJAMD to administer medical treatment as deemed necessary. I understand that there will be a charge of $25.00 for appointments not cancelled 24 hours in advance. I understand that the primary insured is financially responsible for any balance not covered by my insurance, including co-pay, deductible/co-insurance, and any services excluded by my policy. I understand the primary insured will be held responsible for any and all charges incurred by myself or covered dependents should there be no coverage on the date of service. Furthermore, I hereby authorize release of medical information necessary to file a claim with my insurance and assign benefits otherwise payable to me to Gwendolyn J. Allen MD PA.

____
Initials

Medical Care Agreement

I authorize the physicians of GJAMD to instruct their Physician Assistant and Nurse Practitioner to assist in aspects of my medical care. I understand that each time I make an appointment, if my physician is not available in a timely manner, I will be given the choice to be seen by the Physician Assistant/Nurse Practitioner. I acknowledge it is my responsibility to inform the staff of GJAMD if I wish not to see the Physician Assistant/Nurse Practitioner and be scheduled with my physician accordingly. I understand that I may revoke this authorization at any time.

____
Initials

Electronic Communication

By supplying my home/mobile phone number, email address, and any other personal contact information, I authorize my health care provider to employ a third-party automated outreach & messaging system to use my personal information: the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, **for the purpose of notifying me of a pending appointment, missed appointment, overdue wellness visit, or any other reasonable healthcare related communication**. I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, limited protected health information regarding healthcare events, unpaid balances, missed appointments, and to leave a reminder message on my voice mail or answering system if I am unavailable at the number provided by me.

____
Initials

GJAMD Laboratory Testing/Bloodwork

I understand that all Labwork is to be ordered by the provider. I also understand that GJAMD uses Laboratory Corporation of America Holdings(LabCorp) to process the specimens they collect. If I or my insurance company prefers another lab, it is my responsibility to inform medical staff member before the specimen is taken so I may obtain my labs at the proper facility.
I understand that lab draws are performed Tuesday and Thursday mornings from 8:00am-9:00am, and that a follow-up appointment will need to be scheduled to discuss the results of these tests.

____
Initials

GJAMD Prescription Refill Policy

I understand that there is a minimum 48-hour turnaround time on prescription refills. I will request medication refills from my pharmacy and check with the pharmacy to see if it has been completed.
I understand that if I have not been seen in the past 6 months I will need to schedule an appointment for a prescription to be filled.
I understand that antibiotics will not be filled or approved without an appointment with a provider first.
I understand that I am to bring all prescription(s) bottles and over the counter(OTC) supplement bottles (or an updated medication list) with me to each appointment.
I understand that there is a fee for prescriptions that are not filled during an appointment with a provider. I will make every effort to check my medications, diabetic supplies, inhaler, etc. to determine my need for new prescriptions or refills **before my appointment**.
I understand that I will be required to keep regular appointments with my provider for the condition(s) I am being treated for and for the prescriptions that I take, and that I am responsible for making sure that I have enough medication to last until my next scheduled visit with my provider.

____
Initials

Third Party Forms/Applications/Letters

I understand that a fee is assessed for all forms, paperwork or letters and that it may take up to 14 days to complete these items. Fees for completion of all forms/letters etc. are required prior to completion. Fees vary according to the amount and complexity of the paperwork. The staff must review these items prior to making a determination of the fee that will be required.

____
Initials

FMLA (Family Medical Leave) forms

I understand that FMLA forms require an appointment with a provider. Fees for completion of FMLA forms will be required prior to completion and will require 14 days to complete. Fees vary according to the amount and complexity of the paperwork.

____
Initials

Signature:____ Date:________________________

Gwendolyn J. Allen MD

Family Practice

Chronic Care Management Consent Form

I agree to allow Gwendolyn J Allen MD PA to provide me with Chronic Care Management (CCM) services and to be designated my CCM provider. I also understand that other physicians may from time to time provide CCM services to me under this consent.

I understand that these services will include:

- Consultation and guidance in managing my chronic conditions so I can be as healthy as possible
- Reviewing my medications and any questions that I have
- Help with scheduling office visits and tests that my doctor ordered
- Receiving a plan of care with personal health goals
- Sharing of my care plan with other doctors that I see and the staff who are helping with my care
- Working closely with home health and other healthcare resources in my area

I understand that other doctors that I see will receive my medical information electronically through a computer system.

I understand that only one doctor can provide CCM services for me each month and that I may have to pay a monthly co-payment charge.

I understand that I can stop CCM services at the end of any month by contacting the doctor's office through telephone or the patient portal. If I decide to stop these services, I understand that I will no longer receive chronic care management from this doctor's office but this will not have any effect on my usual primary care services.

Patient or guardian signature ____

Printed name ______________________________ Date ____________

NOTICE OF ASSIGNMENT OF BENEFITS TO A PROVIDER

An assignment of benefits is an arrangement by which a patient requests that his or her health insurance benefit payments be made directly to a designated person or facility, such as a physician or hospital.

INSURANCE AUTHORIZATION AND ASSIGNMENT OF BENEFITS

Please be advised that the patient's signature or, in the case of a minor or mentally handicapped individual, the signature of a parent or legal guardian now absolutely provides for the assignment of benefits to Gwendolyn J. Allen, MD, PA, authorizing this transfer of payment from the insured to the healthcare provider, Gwendolyn J. Allen, MD, PA.

I, ____,
(print the full name of the undersigned)
herby absolutely authorize Gwendolyn J. Allen, MD, PA to apply for benefits on my behalf for services rendered to me or my dependent(s) and request that payment be made by my insurance company(ies) and that payment be sent directly to Gwendolyn J. Allen, MD, PA. I understand that it is the policy of Gwendolyn J. Allen, MD, PA to only bill my insurance company(ies) if they participate in that company's network, and if they do not, it will be my responsibility to bill my insurance company(ies) for reimbursement of my expenses.

I certify that I (or my dependent(s)) have active and valid insurance coverage and have supplied Gwendolyn J. Allen, MD, PA with the up-to-date and correct insurance identification card(s) as well as supplied Gwendolyn J. Allen, MD, PA all necessary information regarding the guarantor of the insurance policy(ies) and the necessary information regarding the subscriber(s) eligible for insurance benefits which is required to submit medical claims for reimbursement. Failure to provide updates to any of the information supplied within may result in denial of payment(s) to Gwendolyn J. Allen, MD, PA and resubmitted claims with corrected updated information that are still denied due to the fact that corrected information was not supplied in a timely fashion to Gwendolyn J. Allen, MD, PA and I understand that it will be my responsibility to pay Gwendolyn J. Allen, MD, PA for those medical services rendered to me or my dependent(s). I understand that I am financially responsible for all charges whether or not paid by insurance.

I understand that this in no way relieves me of my primary responsibility to pay for services rendered to me, and if my account is turned over to an attorney for collection or taken to court, I agree to pay any collection fees, reasonable legal fees (25% is deemed reasonable), court cost, and other expenses incurred as a result of said collection or court date, all actions have a venue of Brown County, TX, other venues notwithstanding. Further, I understand that there is a minimum $35.00 for returned checks and a late payment charge not to exceed 1.5% applies to any balance carried forward to next month's bill.

I certify that the information I have reported with regard to my insurance coverage is correct and I hereby authorize Gwendolyn J. Allen, MD, PA, the release of any information relating to any claim for benefits, in order to process any claim for benefits and to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. Furthermore, I permit a copy of this authorization to be used in place of the original. I may revoke this authorization at any time in writing.

______________________________ ______________________________
Signed (Patient or other Person Authorized to Act for Patient) Date Time

____
Print Name

Witnessed By:

______________________________ ______________________________
Relationship to patient Signed(Witness) Date Time

______________________________ ______________________________
Address Printed Name of Witness

____
City State Zip

PATIENT AUTO-PAYMENT AGREEMENT

For your convenience, we are offering a patient balance payment option. This option is designed to help you pay your bill on time every time. You are not required to fill this form out if you do not wish to participate in our Auto-Payment program.

If after a claim has been submitted to my insurance company(ies):

1) The claim is denied as a non-covered service; or
2) The charges deemed a patient responsibility by your insurance company Gwendolyn J. Allen MD has my permission to charge my credit card/debit card on file for services provided to me or my dependent.

I understand that in the vent my credit card or debit card has been charge for medical services, and then my insurance company makes payment to Gwendolyn J. Allen MD PA for those charges, the office will issue a refund or credit to my credit or debit card in the amount received from my insurance company(ies).

I hereby authorize Gwendolyn J. Allen MD PA and its designated payment system to charge my credit or debit card for the full amount of charges for medical services provided. The amount charged will be reflected on my credit/debit card statement.

If payment is denied by my payment card company or bank, I agree to pay the entire amount promptly via another form of payment.

Patient Name: ______________________________ Patient Date of Birth: ______________________

Dependent Name: ______________________________ Dependent Date of Birth: ______________________

______________________________ ______________________

______________________________ ______________________

______________________________ ______________________

______________________________ ______________________

Signature:______________________________ Date:______________________

(You will receive an electronic receipt via email for any transactions processed, provided we have your contact information.)

Gwendolyn J. Allen MD

Family Practice

CONSENT FOR RELEASE OF INFORMATION

Patient Name:____Date of Birth:__________________

Cell phone#: _______________________ Email:_____________________________________

Please check the sections that apply then sign at the bottom of the page:

__________ **I do not give GJAMD permission** to release information to anyone other than myself.

Or

__________ **I give GJAMD permission** to release my information that includes:

__________ Entire Medical Record

__________ Blood Tests/ X-rays

__________ Appointment Details

__________ Billing Information

With

__________ My spouse or significant other (Name ____)

__________ Other Family member (Name ____)

__________ On home answering machine or cell phone # __________________________________

__________ On office/work voice mail# ____

I also give permission to receive all information by mail to address:

____

____

Signature:______________________________ Date:_________________

(**A signature is required for this form to be considered valid)**

Gwendolyn J. Allen MD
Family Practice
1604 14TH St.
Brownwood, TX 76801-5314
(325)646-5296 Fax (325) 646-5820

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name:______________________________ Date of Birth ______________

Address: ______________________________

City State Zip code: ______________________________

SS#:______________________________ Patient Phone #:______________

Date of Request ______________ **Date Needed**:______________

I authorize Gwendolyn J. Allen MD to obtain protected health information from:

____
Name of Provider or Facility

____
Address

____
City, State, Zip Code

____
Phone # Fax #

Reason for Disclosure:
☐ Treatment/Continuing Care
☐ Insurance Coverage
☐ Personal
☐ Other ______________
☐ Transfer of Care
☐ Billing or Claims
☐ Legal Purposes
☐ Disability Determination
☐ School
☐ Employment

What information may be disclosed? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is REQUIRED for the release of some of these items *. If all health information is to be released, then check only the first box.

☐ **All Health Information** * ☐ History/Physical Exam * ☐ Past/Present Medications * ☐ Lab Results *
☐ Physician's Orders * ☐ Patient Allergies ☐ Operation Reports * ☐ Consultation Reports *
☐ Progress Notes * ☐ Discharge Summary * ☐ Diagnostic Test Reports * ☐ EKG/Cardiology Reports
☐ Pathology Reports * ☐ Billing Information * ☐ Radiology Reports & Images * ☐ Other ______________
☐ Mental Health Records (excluding psychotherapy notes) * ☐ Genetic Information (including Genetic Test Results) *
☐ Drug, Alcohol, or Substance Abuse Records * ☐ HIV/AIDS Test Results/Treatments *

DATES REQUESTED: ☐ ALL ☐ LAST 2 YEARS ONLY ☐ FROM ________ TO _______

Effective Time Period. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): ______________

Right to Revoke: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to Gwendolyn J. Allen MD. I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

Signature Authorization: I have read this form and agree to the use and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by the Texas Health & Safety Code § 181.154(c) and /or §164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by recipient and may no longer be protected by federal or state privacy laws.

X______________________________ ______________
Signature of Individual or Individual's Legally Authorized Representative Date

Printed Name of Legally Authorized Representative (if Applicable) ______________
If representative, specify relationship to the individual: ☐ Parent of minor ☐ Guardian ☐ POA (Attach Legal Document) ☐ Other

A Minor individual's signature is required for the release of certain types of information. (i.e. reproductive care, sexually transmitted diseases, drug and alcohol abuse, and mental health treatment) See Texas Family Code §32.003.

X______________________________ ______________
Signature of Minor Individual Date

Gwendolyn J. Allen MD

Family Practice

FEMALE HEALTH HISTORY FORM

Date: ________________

Patient Name:____ Date of Birth:____________________

Previous Primary Care Physician:____

Other physicians (specialists) involved in you care:____

____

Preferred pharmacy: ____

MEDICAL HISTORY:

Have you been diagnosed with any of the following?

Alcoholism ☐Yes ☐ No

Allergies ☐Yes ☐ No

Anemia ☐Yes ☐ No

Anxiety ☐Yes ☐ No

Arthritis ☐Yes ☐ No

Asthma ☐Yes ☐ No

Back Pain ☐Yes ☐ No

Blood Clots ☐Yes ☐ No

if yes, where?______________________________

Cancer ☐Yes ☐ No

If yes, what type?______________________________

Chrohn's/ulcerative colitis ☐Yes ☐ No

Depression ☐Yes ☐ No

Diabetes ☐Yes ☐ No

If yes, what type? ☐ 1 ☐ 2

Emphysema/Lung disease ☐Yes ☐ No

Endometriosis ☐Yes ☐ No

Eye disease ☐Yes ☐ No

If yes, what type?______________________________

Fractures ☐Yes ☐ No

If yes: where? ______________________________

Gout ☐Yes ☐ No

Migraines ☐Yes ☐ No

Hearing Loss/Ear problems ☐Yes ☐ No

Heart Attack ☐Yes ☐ No

Heart Disease ☐Yes ☐ No

If yes: what type? ________________________

Hepatitis ☐Yes ☐ No

If yes: what type? ☐A ☐ B ☐ C

Hernia ☐Yes ☐ No

If yes: what type?______________________________

High blood pressure ☐Yes ☐ No

High Cholesterol ☐Yes ☐ No

HIV ☐Yes ☐ No

HPV Infection ☐Yes ☐ No

Bladder Incontinence ☐Yes ☐ No

Insomnia ☐Yes ☐ No

Kidney Disease ☐Yes ☐ No

Kidney stones ☐Yes ☐ No

Osteoporosis ☐Yes ☐ No

PCOS ☐Yes ☐ No

Stomach reflux ☐Yes ☐ No

Seizures ☐Yes ☐ No

Sleep apnea ☐Yes ☐ No

STDs ☐Yes ☐ No

Stroke ☐Yes ☐ No

Stomach ulcers ☐Yes ☐ No

Thyroid disease ☐Yes ☐ No

If yes: what type?______________________________

Tuberculosis ☐Yes ☐ No

Urinary tract infections ☐Yes ☐ No

Other medical history? ______________________________

____

SURGICAL HISTORY:

Have you had any of the following? Please indicate year.

Abdominal Surgery ☐Yes ☐ No ______yr.

Appendectomy ☐Yes ☐ No ______yr.

Brain surgery ☐Yes ☐ No ______yr.

Back surgery ☐Yes ☐ No ______yr.

If yes: what type? ______________________________

Bladder surgery ☐Yes ☐ No ______yr.

Breast Biopsy ☐Yes ☐ No ______yr.

If yes: location? ☐Right ☐ Left

Breast surgery ☐Yes ☐ No ______yr.

If yes: location? ☐Right ☐ Left

C-Section(s) ☐Yes ☐ No ______yr.

☐Yes ☐ No ______yr.

☐Yes ☐ No ______yr.

Cosmetic surgery ☐Yes ☐ No ______yr.

If yes: what type? ______________________________

Eye surgery ☐Yes ☐ No ______yr.

If yes: what type? ______________________________

Gallbladder removal ☐Yes ☐ No ______yr.

Heart Surgery ☐Yes ☐ No ______yr.

If yes: what type? ______________________________

Hernia repair ☐Yes ☐ No ______yr.

If yes: what type? ______________________________

Hysterectomy ☐Yes ☐ No ______yr.

Ovarian cyst removal ☐Yes ☐ No ______yr.

Thyroid surgery ☐Yes ☐ No ______yr.

If yes: what type? ______________________________

Tubal Ligation ☐Yes ☐ No ______yr.

Other Surgical History? ______________________________

____

OBSTETRIC/GYNECOLOGIC HISTORY:

Age at first period _______ yrs. Period cycle _______ days

Period duration _______ days

Pattern: ☐Regular ☐ Irregular Flow: ☐ Light ☐ Moderate ☐ Heavy

Have you ever been pregnant? ☐ Yes ☐ No

If yes, how many times? ________

Full Term: ______ # Ectopic: _____

Preterm: _______ # Multiple (twins, etc.): ____

Miscarriages: _____ # Living Children: ______

Abortions: ______

Did you have any complication during pregnancy and/or delivery?

☐ Yes ☐ No If yes, please explain: ____________________

Are you currently sexually active? ☐ Yes ☐ No

Partner(s): ☐Male ☐ Female ☐ Both

Method of birth control:

☐ None ☐Pill ☐ Patch ☐ IUD ☐ Injection ☐ Implant ☐ Ring

☐ Tubal ligation/sterilization ☐ Diaphragm ☐ Spermicide ☐ Condom

If you are postmenopausal, when was your last normal period: _________

Are you/have you taken hormone replacement? ☐ Yes ☐ No

If yes, for how long?________________________

Gwendolyn J. Allen MD

Family Practice

ALLERGIES:

Are you allergic to any medications? ☐Yes ☐ No
If yes, please list the name(s) and type of reaction

Name	Reaction

MEDICATIONS:

Do you currently take any prescription medications? ☐Yes ☐ No
If yes, please list medication name, strength, dosage, how often and prescriber below.

MEDCIATION NAME	STRENGTH	HOW OFTEN	PRESCRIBER
		☐ Daily ☐ 2xdaily ☐ 3xdaily ☐ 4xdaily ☐ As needed	
		☐ Daily ☐ 2xdaily ☐ 3xdaily ☐ 4xdaily ☐ As needed	
		☐ Daily ☐ 2xdaily ☐ 3xdaily ☐ 4xdaily ☐ As needed	
		☐ Daily ☐ 2xdaily ☐ 3xdaily ☐ 4xdaily ☐ As needed	
		☐ Daily ☐ 2xdaily ☐ 3xdaily ☐ 4xdaily ☐ As needed	

Do you take any over-the-counter supplements or medicines? (multivitamins, sleep aids, other supplements/medicines)? ☐Yes ☐ No
If yes, please list name of supplement/medicine, amount, how often, and reason for taking below.

NAME OF SUPPLEMENT/MED	AMOUNT EXAMPLE: 500 MG, 1 TABLET	HOW OFTEN	REASON FOR TAKING:

FAMILY HISTORY:

☐Adopted/ ☐Unknown – Please complete Your Child(ren) information, if applicable, and continue to next section.

Family Member:	Name	Living?	Current Age/ Age at Death	If Deceased Cause of Death	High Blood Pressure	Heart Attack	Heart Disease	Stroke	Diabetes	Breast Cancer	Colon Cancer	Prostate Cancer	Other Cancer	Alcoholism	Allergies	Anemia	Arthritis	Asthma	Birth Defects	Blood Clotting Problem	Colitis	Seizures/Epilepsy	Genetic Disease	Glaucoma	Gout	Kidney Disease	Mental Illness	Migraines	Osteoporosis	Thyroid Disease	Tuberculosis	Ulcer	Other
Your Mother:					☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Your Mother's Mother:					☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Your Mother's Father:					☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Your Father:					☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Your Father's Mother:					☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Your Father's Father:					☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Your Brother(s):					☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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Your Sister(s):					☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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Your Child(ren):					☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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SOCIAL HISTORY:

Marital status: ☐Single ☐Separated ☐ Married ☐Divorced ☐Widowed
Occupation: ______________________________________
Do you currently use tobacco products? ☐ Yes ☐ No
Go To **
Have you EVER used tobacco products? ☐ Yes ☐ No
If Yes, when did you quit? (month/year) ___________
**Type: ☐ Cigarette ☐ Cigar ☐ Hookah ☐ Chew/Dip ☐ Pipe ☐ E-cig/Vape
Packs per day: _____ for how many years? ______ Yrs.
Does anyone in your home smoke? ☐ Yes ☐ No

Alcohol use ☐ Yes ☐ No
If yes: # drinks _____ per ☐day ☐week ☐month ☐year ☐rarely
Type of alcohol ______________________________
Are other concerned by your drinking ☐ Yes ☐ No
Street Drug use ☐ Yes ☐ No
If yes: type(s) __________________________
Do you exercise? ☐ Yes ☐ No
How Often? __________times per week
Type of exercise ___________________________

HEALTH MAINTENANCE:

If you have had any of the following, please specify date last performed:

Pap smear ☐Never _____/ _____/ _____
Have you ever had an abnormal pap smear? ☐ Yes ☐ No
When: _____/ _____/ _____
How was it treated?____________________________
Mammogram _____/ _____/ _____
Have you ever had an abnormal mammogram? ☐ Yes ☐ No
If yes, how long ago? ____
Colonoscopy ☐Never _____/ _____/ _____
Result: ☐ Normal ☐ Polyps ☐ Diverticula
☐ Hemorrhoids ☐ Other: ___________________
Bone density scan ☐Never _____/ _____/ _____
Result: ☐ Normal ☐ Osteopenia ☐ ☐ Osteoporosis
CT for lung cancer screening ☐Never _____/ _____/ _____
Dental Exam ☐Never _____/ _____/ _____
Eye Exam ☐Never _____/ _____/ _____
Tetanus Shot ☐Never _____/ _____/ _____
HPV series (3) ☐Never _____/ _____/ _____
Flu Shot ☐Never _____/ _____/ _____
Pneumonia Shot
Pneumovax ☐Never _____/ _____/ _____
Prevnar 13 ☐Never _____/ _____/ _____
Shingles vaccine ☐Never _____/ _____/ _____
Hepatitis A vaccine ☐Never _____/ _____/ _____
Hepatitis B vaccine series ☐Never _____/ _____/ _____
Meningitis vaccine ☐Never _____/ _____/ _____
MMR (measles, mumps, rubella) ☐Never _____/ _____/ _____
Varicella vaccine ☐Never _____/ _____/ _____

Gwendolyn J. Allen MD

Family Practice

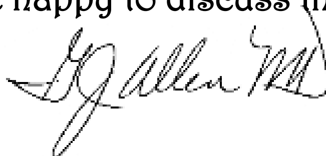
ALLERGY SURVEY

Name: ______________________________ Age: __________ Date: ____________________

Do you experience any of the following? Check the box that best describes your answer.

		Never	Rarely	Sometimes	Often	Always
1.	Sneezing	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
2.	Stuffy Nose	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
3.	Runny Nose	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
4.	Itchy Nose	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
5.	Water Eyes	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
6.	Burning Eyes	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
7.	Itchy Eyes	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
8.	Itchy Ears	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
9.	Ringing in the Ears	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
10.	Post Nasal Drip	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
11.	Hoarseness	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
12.	Headaches	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
13.	Hives/Welts	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
14.	Rashes	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
15.	Cough	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
16.	Fatigue/Tiredness	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
17.	Wheezing	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
18.	Asthma	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
19.	Sinus Infections	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
20.	Bronchitis	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
21.	Other:	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
	Total Score:					

If you scored more than 5 points, you may benefit from being tested for allergies. We will be happy to discuss this with you during your appointment today!



1. Have you taken any allergy or cold medicines over the past 5-7 days? ☐ Yes ☐ No
   If yes, which ones? ______________________________

2. Do you take medicines for blood pressure or your heart? ☐ Yes ☐ No
   If yes, which ones? ______________________________

3. List any other medications (prescription or OTC) you have taken over the past week: ______________________________

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