

Gwendolyn J. Allen MD

Family Practice

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

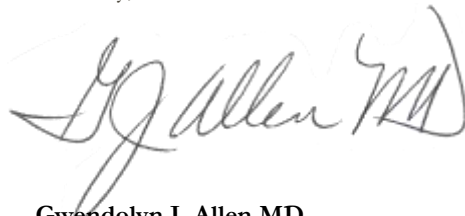
Welcome,

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,

A handwritten signature in black ink that reads "GJ Allen MD". The signature is written in a cursive style with a large, stylized initial "G".

Gwendolyn J. Allen MD

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REGISTRATION FORM

Today's date:						
PATIENT INFORMATION						
Patient's Last name:		First:	Middle:	Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No		If not, what is your legal name?	(Former name):	Birth date:	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
check all that apply Race: <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> African American <input type="checkbox"/> Hawaiian <input type="checkbox"/> Caucasian/White <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Other: _____			Spoken Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Occupation:	Employer:	Employer address:		Employer phone no.:		
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Please indicate primary ins. <input type="checkbox"/> BCBS <input type="checkbox"/> Aetna <input type="checkbox"/> Cigna <input type="checkbox"/> Tricare <input type="checkbox"/> Humana <input type="checkbox"/> Medicare <input type="checkbox"/> United Healthcare <input type="checkbox"/> CHIP's <input type="checkbox"/> Medicaid <input type="checkbox"/> Other _____						
Subscriber's name:		Subscriber SS#.:	Birth date:	Group no.:	Policy no.:	
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other (please specify): _____						
Name of secondary insurance (if applicable):		Subscriber's name:		Group no.:	Policy no.:	
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> 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			

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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

Gwendolyn J. Allen MD

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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

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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 event my credit card or debit card has been charged 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.)

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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.

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> All Health Information * | <input type="checkbox"/> History/Physical Exam * | <input type="checkbox"/> Past/Present Medications * | <input type="checkbox"/> Lab Results * |
| <input type="checkbox"/> Physician's Orders * | <input type="checkbox"/> Patient Allergies | <input type="checkbox"/> Operation Reports * | <input type="checkbox"/> Consultation Reports * |
| <input type="checkbox"/> Progress Notes * | <input type="checkbox"/> Discharge Summary * | <input type="checkbox"/> Diagnostic Test Reports * | <input type="checkbox"/> EKG/Cardiology Reports |
| <input type="checkbox"/> Pathology Reports * | <input type="checkbox"/> Billing Information * | <input type="checkbox"/> Radiology Reports & Images * | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Mental Health Records (excluding psychotherapy notes) * | | <input type="checkbox"/> Genetic Information (including Genetic Test Results) * | |
| <input type="checkbox"/> Drug, Alcohol, or Substance Abuse Records * | | <input type="checkbox"/> 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

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MALE 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
- 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
- Incontinence Yes No
- Insomnia Yes No
- Kidney Disease Yes No
- Kidney stones Yes No

- Osteoporosis Yes No
- Prostate enlargement 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? _____
- Testicular torsion Yes No
- Tuberculosis Yes No
- Urinary tract infections Yes No

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.
 - 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? _____
 - Prostate surgery Yes No _____ yr.
 - Thyroid surgery Yes No _____ yr.
If yes: what type? _____
 - Vasectomy Yes No _____ yr.

Other Surgical History? _____

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, frequency and prescriber below.

MEDCIATION NAME	STRENGTH& DOSE	FREQUENCY	PRESCRIBER
		<input type="checkbox"/> Daily <input type="checkbox"/> 2xdaily <input type="checkbox"/> 3xdaily <input type="checkbox"/> 4xdaily <input type="checkbox"/> As needed	
		<input type="checkbox"/> Daily <input type="checkbox"/> 2xdaily <input type="checkbox"/> 3xdaily <input type="checkbox"/> 4xdaily <input type="checkbox"/> As needed	
		<input type="checkbox"/> Daily <input type="checkbox"/> 2xdaily <input type="checkbox"/> 3xdaily <input type="checkbox"/> 4xdaily <input type="checkbox"/> As needed	
		<input type="checkbox"/> Daily <input type="checkbox"/> 2xdaily <input type="checkbox"/> 3xdaily <input type="checkbox"/> 4xdaily <input type="checkbox"/> As needed	

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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 <small>EXAMPLE: 500 MG, 1 TABLET</small>	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
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your Mother:					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Your Mother's Mother:					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Your Mother's Father:					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Your Father:					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Your Father's Mother:					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Your Father's Father:					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Your Brother(s):					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Your Sister(s):					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Your Child(ren):					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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 _____
 Are you currently sexually active? Yes No
 Partner(s): Male Female Both
 Do you use protection? Yes No

HEALTH MAINTENANCE:

If you have had any of the following, please specify date last performed:
 Prostate exam Never ____/____/____
 PSA Never ____/____/____
 Colonoscopy Never ____/____/____
 Result: Normal Polyps Diverticula
 Hemorrhoids Other: _____
 Aortic aneurysm screening Never ____/____/____
 CT for lung cancer screening Never ____/____/____
 Dental Exam Never ____/____/____
 Eye Exam Never ____/____/____
 Tetanus Shot Never ____/____/____
 HPV series (3) Never ____/____/____
 Flu Shot Never ____/____/____
 Pneumonia Shot Never ____/____/____
 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

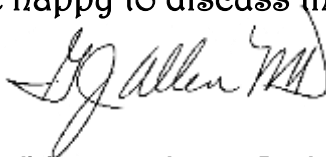
Name: _____ Age: _____ Date: _____

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

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