CARE PLUS
Primary Care • Urgent Care

❑ 8914 US Highway 431
Albertville, AL 35950
P: 256.279.7200
F: 256.279.5757

❑ 700 Quintard Avenue
Anniston, AL 36201
P: 256.236.9400
F: 256.403.2008

❑ 11100 S. Memorial Pkwy
Huntsville, AL 35803
P: 256.650.4665
F: 256.650.4624

NAME: _____ Birthdate: _____ Today's Date: _____
Last First Middle Initial

Please fill out this form as accurately and completely as possible. This information will be used as part of your permanent medical record.

Do you use any of the following? If yes, please check and fill out the additional information.

❑ Tobacco - Type: _____ Amount per day?: _____ #Years: _____

❑ Alcohol Products - Type: _____ Amount per day?: _____ #Years: _____

❑ Illegal Drugs - Type: _____ Amount per day?: _____ #Years: _____

List any past medical problems or surgeries and include dates of surgery or dates of diagnosis if known

SURGERIES	DATE	COMPLICATIONS
MEDICAL PROBLEMS	**LENGTH OF ILLNESS**	**COMPLICATIONS/SYMPTOMS/CONTROLLED/UNCONTROLLED**

Female: Menstrual History: Date of Last Period _____ ❑ Regular Periods ❑ Irregular Periods ❑ Menopause

Date of Last Pap Smear _____ Date of Last Mammogram _____

ALLERGIES - List any medication, food or environmental allergies and the type of reaction you experience. _____

List any medication you take on a regular basis and also any over-the-counter medications you use more than once a month. Please specify the name of the medication, the number and dose of each pill and the frequency in which you take each. Please list any problems or side effects if any you experience with any of these medications such as "upset stomach", "itching", etc.

Medication	Dose	Frequency	Problems		Medication	Dose	Frequency	Problems

I have reviewed the medical and family history on the above patient for the following dates of service.

Date	Initials		Date	Initials		Date	Initials		Date	Initials

Family Medical History. Please fill out as completely and accurately as possible. This will be a part of your permanent medical record and will be updated on each visit. Use the first block as an example.

Family Member	Health Status	Arthritis	Cancer	Diabetes	Heart Condition	Lung Disease	Mental Illness	Stroke	Other	If deceased, date and cause of death
EXAMPLE	Good Fair Poor	YES			Heart attack 1989	Emphysema			Sickle Cell Anemia	1989 Heart Attack
Yourself										
Mother										
Father										
Sibling										
Sibling										
Sibling										
Grandparents Paternal										
Grandparents Maternal										
Children										
Children										
Children										

Immunization Record. Please fill out as completely as possible. If patient is a child and you have a copy of their immunization card please bring the card to the receptionist with insurance card to be copied.

Immunization	Date	Date	Date	Date	Date	Date	Date
Tetanus Toxoid DTP-DT/Td/Hib							
OPV "Polio"							
TB Skin Test							
MMR							
Varicella							
Influenza							
Pneumovac							

Immunization	Date	Date	Date	Date	Date	Date	Date
Gamma Globulin							
Chicken Pox Vaccine							
Hepatitis "B"							
Hepatitis "A"							

I have completed the medical history and family history as accurately and as completely as possible. I understand that this will become a part of my permanent medical history.

Patient Signature/Responsible Party _____ **Date** _____ **Witness (Triage Personnel)** _____ **Date** _____

Do you have an Advanced Directive? ☐ Yes ☐ No

FOR PHYSICIAN USE ONLY

Annual Test Therapeutic Diagnostic Testing	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date
Pap / PSA										
Mammogram										
Hemoccult										