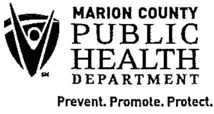

Name: ______________________________ MCPHD# ____________

Date of birth: ____________ Preferred Pharmacy: ____________________

Please circle any of the following, which the patient has had or has currently:

ADHD/ADD	Cancer	Lung Disease	Breast Disease	Diabetes
Allergies	Depression	Obesity	Sinus Problems	Genetic Disorders
Anxiety	Migraines	Pregnancy	Thyroid Disease	Female Health Problems
Arthritis	Heart Conditions	Seizures	Substance Abuse Problems	Male Health Problems
Asthma	Hepatitis	Sexually Transmitted Infections	Skin Problems	
Bleeding Disorders	High Blood Pressure	Stroke	Ear/Nose/Throat Problems	
Bowel Disorder	High Cholesterol	Back Problems	Eye Problems	
Bladder Disorder	Kidney Disease	Neck Problems	Surgery	

Please circle any of the following, if applicable:

Birth Control

Abstinence
Condoms
Depo-Provera Shot
Implanon
IUD
Ring
Patch
Pills
Never Sexually Active
Other

Employed

Full Time
Student
Part Time
Disabled
Unemployed

Do you Smoke?:

❑ Yes ❑ No

If "yes" please list:

Type: ____________

How Much: ________

Years: ________

Do you drink Alcohol?:

❑ Yes ❑ No

If "yes" please list:

Type: ____________

How Much: ________

Years: ________

Marijuana or other illicit drug use?

❑ Yes ❑ No

If "yes" please list:

Type: ____________

How Much: ________

Years: ________

Do you have any diseases, conditions or problems not listed above?

❑ Yes ❑ No

If "yes" please list:

____

____

____

Are you allergic to any medicine, drug, food or other substance?

❑ Yes ❑ No

If "yes", please list:

____

____

____

Medications:

Name: ______________________________

Dose: ____________ Frequency: ________

Name: ______________________________

Dose: ____________ Frequency: ________

Name: ______________________________

Dose: ____________ Frequency: ________

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have a change in my health, or if my medicines change, I will inform the doctor at the next appointment. Specific medical procedures will be explained to me. I understand that I/my child may not be able to receive all of the desired services from the Marion County Public Health Department and my treatment may require the need for me to be referred to other medical providers due to the nature of my medical problem. I understand all medical procedures have benefits as well as certain risks, including possible side effects from some medications used in medical practice. These risks include, but are not limited to allergic reactions, tenderness, bruising from injections, and infections, serious complications or conditions.

Patient/Parent/Guardian signature: ______________________________ Date: ____________

I also authorize and agree that the Health and Hospital Corporation of Marion County may keep or compile health information in any manner and is hereby authorized to use any treatment records, x-rays or photography for teaching or research purposes, including scientific journals or government-related publications. Patient confidentiality will be protected. Parent's name or other private identifying information will not be released.

Patient/Parent/Guardian signature: ______________________________ Date: ____________

I hereby authorize insurance benefits to be paid directly to the medical provider or their representative (Health and Hospital Corporation). I also authorize the medical provider or other appropriate staff or representative to release information required to process claims and agree that a photocopy of this authorization is as valid as the original. I also agree that the Marion County Public Health Department may release a copy of my medical record, or any portion thereof, or other information to the health professionals involved with my medical care.

Patient/Parent/Guardian signature: ______________________________ Date: ____________