James Durward Black MD 300 Courtyard Dr SE Ste B Cartersville, GA 30120 (770) 386-1076

Patient Information:

Patient Name: ____

Address: ____

City: ________________________________**State:** _______**Zip:**______________

Patient's Social Security Number: ____

Patient's Date of Birth: ____________**Cell Phone Number:** _____________________

Home Number: __________________**Work Number:** ________________________

Please put a Star * by the Phone Number that is your preferred Contact Number:

May Messages be left on your cell or home numbers? ________________________

EMAIL Address: ____

Occupation/Work Name: ____

Occupation/Work Number: ____

Work Address/City/State:____

Highest Grade Level Completed: ____

Primary Language: _______________________Secondary: _______________________

Emergency Contact Name: ____

Emergency Contact Phone Number: ____

PRIMARY PHYSICIAN NAME: ____

PRIMARY PHYSICIAN NUMBER: ____

PRIMARY PHYSICIAN CITY: __________________________STATE ___________________

Patient Name: _______________________________D.O.B. _______________________

PHARMACY NAME: ____________________________NUMBER:____________________

ADDRESS: ____ CITY: _____________________________STATE: _________ZIP: ________________

May we leave a message on your voicemail or answering machine?

Yes ___________ NO _______________

May we email you about test results? (make sure email is listed above in email line) Yes ___________ NO _______________

Who may have access to your medical records/information regarding your care from Dr. Black other than yourself? List Below:

Name / Phone Number / Relationship

____

Name / Phone Number / Relationship

____

Intake Forms for Patients **Patient Name** __________________________

Medical History **Patient Date of Birth:** ___________________

What questions, concerns, or problems would you like to discuss during your visit with Dr. Black?

____

____

Pharmacy Name: Preferred: _______________________Mail Order: _________________________

List any **allergies**, including your reaction: (Ex: short of breath, hives, etc.)

____

List any current **prescription medications** you are taking: (or attach copy)

____

____

Social History:

Select your tobacco use status:

XX Mark Current Tobacco use below	XX Mark Current Tobacco use below
Non-Smoker	Very Heavy Cigarette Smoker (40+ cigs/day
Ex-Smoker	Chain Smoker
Occasional cigarette smoker	Chews products containing tobacco
Light cigarette smoker (1-9 cigs/day)	Cigar Smoker
Moderate cigarette smoker(10-19 cigs/day)	Pipe Smoker
Heavy cigarette smoker (20-39 cigs/day)	Snuff User

Vaping	Smokeless Tobacco Product (any other)

If you have quit using tobacco products approximately what year did you quit? ______

How many years did you or have you smoked? ____

How often do you drink alcohol?
___None___Rarely___Occasional with Dinner___Weekends___ 1 to 2 drinks per day___3+ Drinks/Day

List any illegal substances you use or have used:

What is your marital status: ___Single___Married___Divorced___Widowed___Separated___Domestic Partner

Do you have children? ___Yes ___No **If yes, how many children** _____

Select your highest level of education:___High School ___Some College___CollegeDegree ___Advanced Degree___Trade School

Work History: ***Are you employed*** ___Yes___No ***Are you Retired?*** ___Yes ____NO

Name of Employer & Telephone Number: ____

Please check below any of the following work related exposures you have experienced (past or present)
___Firefighter/Smoke ___OilExposure___HairStylist ___Painting ___Manufactoring___Plastics
___Mechanic ___Salvage Yard

Surgical History:
Place an XX by any SURGERIES you have had in the past or that you have been advised to schedule (if not listed complete the box below)

XX Abdominal Surgeries	**XX Orthopedic Surgery**
Appendectomy	Hip
Colon Resection	Knee
Gallbladder	Shoulder
GERD	
Hernia	**XX Spine Surgery**
Weight Loss Surgery	Chest
XX Urologic Surgery	Low Back
Bladder Tumor/Biopsy	Neck
BPH Surgery (Enlarged Prostate)	
Kidney Removal	**XX Vascular Surgery**
Kidney Stone Surgery	Bypass Graft
Prostate Biopsy	Stent

Prostate Cancer Surgery	
Vasectomy	**XX Female Surgery**
	Breast Implants
XX Gastrointestinal Surgery	Hysterectomy (Partial)
Colonoscopy	Hysterectomy (Complete)
EGD	Mastectomy
Ulcer Surgery	Tubal Ligation
XX Heart Surgery	
Stents	**XX Eye Surgery**
Bypass Surgery (CABG)	Cataracts

______**Check if NO SURGICAL HISTORY**

Any other surgeries not listed above:
____

REVIEW Of SYSTEMS (IMPORTANT please mark and **X** by any health issues you have**)**

XX CONSTITUTIONAL	**XX Hematologic**	**XX Psychiatric**
Fatigue	Anemia	Anxiety
Temperature/chills	Easy Bruising	Bipolar
Weight Change	Hemophilia	Depression
	Leukemia	PanicAttacks
XX EYES	CLL	Schizophrenia
Cataracts	ALL	
Glaucoma	AML	**XX Neurologic**
Vision Changes	Polycythemia	Change in Memory
		Dementia
XX RESPIRATORY	**XX SKIN**	Disc Disease
Asthma	New Lesions	Dizziness
COPD	Psoriasis	Hemiplegia
CPAP	Rash	Paraplegia
Home Oxygen Use	Sebaceous Cyst	Parkinson's Disease
Lung Cancer		Quadriplegia
Shortness of Breath	**XX Ear, Nose, Throat**	Sciatica
	Hearing Loss	Seizure Disorder
XX Gastrointestinal	Wears Dentures	Stroke (CVA)
Abdominal Pain	Nose Bleeds	Tremor
Bloody Stools		Unable to Balance
Bowel Habits Change	**XX Cardiovascular**	
Constipation	A-Fib	**XX Infectious Disease**
Diarrhea	ArtificialHeartValve	AIDS
Hepatitis	Chest Pain	Hepatitis A
Nausea/Vomiting	Cholesterol Elevated	Hepatitis B
Rectal Bleeding	Edema/AnkleSwelling	Hepatitis C

Reflux	Heart Attack	Herpes
Ulcers	HighBloodPressure	HIV
	Pacemaker	HPV
XX Muscular	Palpitations	
Arthritis	Stents	
Gout		**XX Urologic (Con't.)**
Joint Pain	**XX Urologic**	Erectile Dysfunction
Joint Stiffness	Bladder Cancer	Interstitial Cystitis
Low Back Pain	Blood in Urine	Kidney Cancer
Neck Pain	BPH(Enlarged Prostate)	Kidney Disease
Total Joint	Breast Cancer	On Dialysis
	Change in Stream	Kidney Stone
XX Endocrine	Elevated PSA	Overactive Bladder
Adrenal	**XX Endocrine (Con't.)**	Peyronie's Disease
Diabetes Type I	Low Testosterone	Prostate Cancer
Diabetes Type II	Pituitary	Urinary Tract Infection
______Most Recent A1C	Thyroid Disease	
XX Add Any other Health	**Problems Below:**	

Family History: (check below your blood relatives any of the issues on the left)

	Mother	**Father**	**Sister**	**Brother**	**Grandfather**	**Grandmother**
Kidney Stones						
Dementia						
Depression						
Diabetes Type I						
Diabetes Type II						
Heart Disease						
High Blood Pressure						
Bladder Cancer						
Kidney Disease						
Kidney Cancer						
Blood in Urine						
Stroke						
Substance Abuse						
Prostate Cancer						
Cancer (any type)list type below						

____________________________	______	_____	____	______	__________	____________
____________________________	______	_____	____	______	__________	____________
____________________________	______	_____	____	______	__________	____________

Please list below any types of cancer or any other family medical history:

Do you have Advanced Directives? _____Yes _____No (If yes please provide a copy on your next visit)

Do you have a Durable Power of Attorney for Medical Care? ____Yes ____No (If yes please provide a copy on your next visit)

List any special hobbies or any jobs with chemical exposure:

____