New Patient Intake Instructions

Please complete and return to the office. Once received, the office will contact you to schedule an appointment.

You may return the intake paperwork in one of the following ways:

- Drop it off at our office at 333 Whitesport Drive SW Ste 204, Huntsville, AL 35801
- Fax it to the office at 256-664-9129
- Email to frontdesk@frenchfamilypractice.com

  *Please be aware that emails are not a secure way of sending your personal health information. If you choose to email your information, you are doing so at your own risk.

French Family Practice

HUNTER FRENCH, MD
333 WHITESPORT DRIVE, SUITE 204 – HUNTSVILLE, AL 35801
PHONE: (256) 715-5001 | FAX: (256)664-9129

Patient Information

Patient Name _____ **Gender M F Other**

Date of Birth _____ **Social Security #** _____

Address _____

Phone _____ **Alt Phone** _____
Home / Mobile / Work **Home / Mobile / Work**

Email _____

Preferred Pharmacy _____

Insurance information

Insurance Carrier _____ **Policy ID** _____

Policy Holder _____ **Policyholder DOB** _____

Secondary insurance (if applicable) _____

Emergency Contact Information

Name _____ **Phone** _____ **Relationship** _____

French Family Practice

Medication History/ Prescription Writing Policy

Our electronic medical records allows us to collect and review your medication history. A medicatio history is a list of prescriptions that healthcare providers have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history. Medication history is very important in helping providers treat your symptoms and/or illness properly and avoid potentially dangerous drug interactions. It is very important that you and your provider discuss all your medications in order to ensure that your recorded medication history is 100% accurate. Some pharmacies do not make prescription history information available, and your medication history might not include drugs purchased without using your health insurance. Over-the-counter drugs, supplements, or herbal remedies that you take on your own may not be included.

French Family Practice strives to build long-term, partnering relationships with our patients. We believe prevention of disease and promotion of healthy lifestyles are critical for patients' well-being and long-term health. In our experience, the risk of chronic use of certain medications outweigh the potential benefits. For this reason, and for the safety of our patients, **we do not provide the following prescriptions:**

- Narcotic pain medications (Morphine, Dilaudid, Tramadol, Oxycodone, Hydrocodone, etc.)
- Controlled substances (Xanax, Klonopin, Valium, Adderall, Vyvanse, etc.)

I have received and reviewed the Medication History/Prescription Writing Policy for French Family Practice. I understand that French Family Practice/Dr. French reserves the right to change, modify or delete any part of this policy at any time. By signing below, I acknowledge full understanding of this policy and give my permission to allow my healthcare provider to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.

_____ _____

Print Name Signature

_____ _____

Office Staff Date

French Family Practice

Health History Questionnaire

Patient Name: _____ Patient DOB:_____

Preferred Pharmacy: _____

List any specialists you currently see: _____

_____

Allergies: _____

_____

Medication List:

(please list name of medication and dose)

_____

_____

_____

_____

_____

_____

_____

Immunization History

Influenza: _____ Covid-19: _____ Pneumovax: _____

Tetanus: _____ Shingles: #1 _____ #2 _____

Past Medical History

Please check all that apply:

- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety
- ☐ Asthma
- ☐ Bipolar Disorder
- ☐ Blood Clots
- ☐ Cancer (please indicate type below)

  _____
- ☐ COPD
- ☐ Dementia/Memory Loss
- ☐ Depression
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Heart Attack
- ☐ Heartburn/Gastric Reflux
- ☐ High Cholesterol
- ☐ Hypertension
- ☐ Kidney Disease
- ☐ Osteoporosis
- ☐ Seizures
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Ulcers
- ☐ Other (please specify)

  _____

Family History

	Mother	Father	Sister	Brother	Son	Daughter
Asthma						
Dementia						
Depression						
Diabetes						
Heart Disease						
High Blood Pressure						
High Cholesterol						
Kidney Disease						
Stroke						
Substance Abuse						
Parkinson's						
Lupus						
Cancer (specify type below)						

Surgical History

_____

_____

_____

_____

_____

_____

_____

Smoking Status

- ☐ Never Smoked
- ☐ Former Smoker
  - Smoked For: _____
  - Quit Date: _____
- ☐ Current Every day Smoker
  - How Long: _____

Please Circle all that apply:

Tobacco Vape Other

Alcohol Use

Do you drink alcohol

Yes No

Type: Beer Wine Liquor

How Often? _____

Health Maintenance / Screenings

Last colonoscopy date _____

Females only: Pap smear date: _____ Mammogram date: _____

Anything else we should be aware of:

_____

_____

_____

_____