

Medical History

Please fill in the circle for all **previous** illnesses or conditions below:

- Anxiety/Depression
- Asthma
- Cancer
- Heart Disease
- High Blood Pressure
- History of Blood Clots
- HIV/AIDS
- Kidney Problems
- Liver Disease
- Lung Problems
- Arthritis
- Bleeding Disorder
- Bowel/Intestinal Problems
- Diabetes (high blood sugar)
- Hearing Problems
- Glaucoma/Eye Problems
- Mental Health Problems
- Seizures
- Skin Problems
- Stomach Problems
- Stroke
- Thyroid Disease
- High Cholesterol
- Anemia
- Seasonal Allergies
- Acid Reflux/GERD

Comments/Additional information: _____

Other Doctors you see: Name and Specialty

Concerns you would like to address today and reason for visit: _____

Past Surgeries/Hospital stays

Date Surgery type and/or hospital stays

Family History

Please provide siblings/children history in additional boxes.

Relation	Mother	Father							
Living or deceased									
Current age or age of death									
Diabetes									
High/Low Blood pressure									
Heart disease/Heart attack									
Stroke									
Mental Illness									
Cancer									
Unknown									

Comments/Additional information:

Social History

Do you smoke? Yes / No / Former Smoker

If Yes, How often _____ What do you smoke? _____

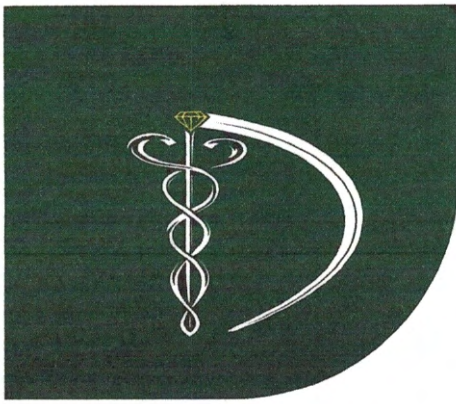
How long have you smoked? _____ Do you plan on quitting? _____

Do you drink Alcohol? Yes / No / Former Drinker

If Yes, How often _____ What do you drink? _____

How much do you normally drink? _____

Any current or history of illegal drug use? Yes / No



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Acknowledgement of receipt of notice of Health Information Practices

The Health Insurance Portability and Accountability Act (HIPAA) is a federal government regulation designed to ensure that you are aware of your privacy rights and how your medical information can be used by our staff in providing and arranging your medical care.

Permissions regarding the consent to disclose your protected health information for informative purposes and/or treatment provided by Diamond Odell Jude, M.D. are granted on this form.

**HIPAA Information Release
Release my information to:**

	Name	Relationship
Myself		
Spouse		
Individual		
Individual		
Individual		

1.) May our office leave detailed information on your answering machine?
Yes ___ No ___

2.) May we send appointment reminders and messages via email/text?
Yes ___ No ___

By signing this form, you acknowledge that you have provided Diamond Odell Jude, M.D. LLC with permission/instructions regarding the release of your healthcare information.

Signature of Patient, Parent or Legal Guardian Date
