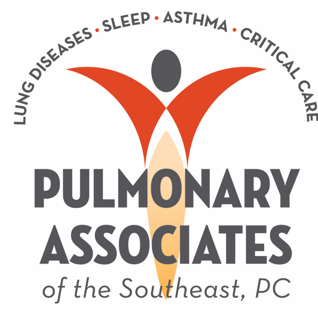
Main Office
880 Montclair Road, Suite 270
Birmingham, AL 35213-2437

St. Vincent's Blount
150 Gilbreath Drive
Oneonta, AL 35121

Northside Medical Center
70 Plaza Drive
Pell City, AL 35125



Gardendale Clinic
2215 Decatur Highway, Suite 117
Gardendale, AL 35071

Sylacauga Clinic
Medical Arts Building, Suite 124
120 South Anniston Avenue
Sylacauga, AL 35150

Chelsea Clinic
16691 Hwy 280
Chelsea, AL 35043

Russell G. Beaty, M.D • Sandra K. Gilley, M.D. • Allan R. Goldstein, M.D. • W. Bishop Kelley, M.D. • Karl T. Schroeder, M.D. • Alan Q. Thomas, M.D.

PATIENT INTAKE FORM

Name: ______________________________ Date of birth: ______________

Name of Physician that referred you: ______________________________

Briefly describe your symptoms: ______________________________

Past Medical History:

_______ COPD _______ Acid Reflux _______ Hypertension _______ Thyroid Disorder

_______ Nodule/Mass _______Diabetes _______ Heart Failure _______ High Cholesterol

_______ Asthma Other: ______________________________

Past Surgery History:

_______ Appendectomy _______ Hysterectomy _______ Gallbladder _______ Hernia

_______ Heart Bypass _______ Tonsils _______ Hip _______ Back

_______ Prostate _______ Other: ______________________________

List the names of all medicines you take including any supplements and over the counter:

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

Allergies:

_______ None Other: ______________________________

Family History: *Please check if your Mother, Father, Brother, Sister ever had any of the following*

_______ Lung Cancer _______ Heart Disease _______ High Blood Pressure _______ Diabetes

_______ Prostate Cancer Other: ______________________________

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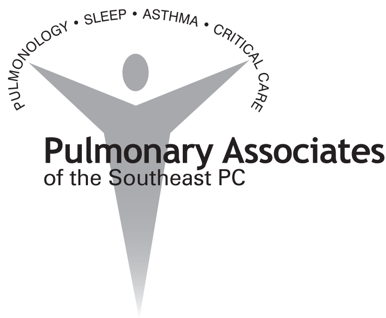

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PATIENT INTAKE FORM

Social History:

Tobacco _______Current / Everyday _______Former Years ______________

_______Current / Some Days _______Never Packs ______________

Alcohol _______Current / Everyday _______Former Amount ______________

_______Current / Some Days _______Never

Status ☐Single ☐Married ☐Divorced ☐Widowed

Review of Systems:

1. Are you having fatigue? _______Yes _______No
2. Have you had recent weight gain loss? If so, how much?______________________________________
3. Are you having headaches? If so, describe: _______Yes _______No

____

4. Are you having an earache? _______Yes _______No
5. Do you have hearing loss? _______Yes _______No
6. Visual problems not connected with glasses? _______Yes _______No
7. Sinus congestion or postnasal drip? _______Yes _______No
8. Have you been told you: Snore Stop breathing ... during sleep? _______Yes _______ No
9. Have trouble getting to sleep? _______Yes _______No
10. Feel rested in the morning? _______Yes _______No
11. Excessive daytime sleepiness? _______Yes _______No
12. Shortness of breath? If so, (check) at rest with activity both _______ Yes _______No
13. Do you wheeze? _______Yes _______No
14. Do you cough? _______Yes _______No

    If so, are you coughing up anything? _______Yes _______No

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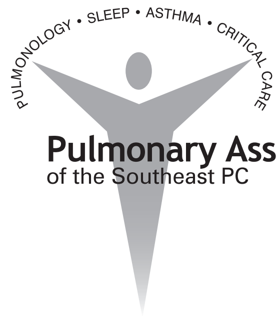

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PATIENT INTAKE FORM

15. Do you have palpitations? _______Yes _______No

16. Do you have chest pain? _______Yes _______No

17. If so, how long does each episode last? _________________________ with (check) Rest Activity Both

18. Is the chest pain associated with (check): Nausea Sweating Shortness of breath

19. Does the chest pain radiate: across chest down arm up neck _______Yes _______No

20. Do you have diarrhea? _______Yes _______No

21. Do you have constipation? _______Yes _______No

22. Do you have blood in stool or dark black stool? _______Yes _______No

23. Do you have abdominal pain? _______Yes _______No

24. Do you have reflux of stomach / indigestion? _______Yes _______No

25. Do you have blood in your urine? _______Yes _______No

26. Pain or burning with urination? _______Yes _______No

27. Do you have loss of bladder control? _______Yes _______No

28. Any muscle or joint aches? _______Yes _______No

29. Any numbness or weakness in arm or leg? _______Yes _______No

30. Any anxiety or depression? _______Yes _______No

Anything else you would like for us to know about your health:

____

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