

FAMILY MEDICAL HISTORY

<input type="checkbox"/> I don't know the medical history of my biological parents or other family members (Go to next section)	Mother: ___ Alive Age: ____ Deceased at age: ____ because of _____	Father: ___ Alive Age: ____ Deceased at age: ____ because of _____	Number of Living brothers/sisters ____ Number of deceased brothers/sisters ____ Cause(s) _____
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Members of my family (parents, brothers/sisters, grandparents, aunts/uncles) suffer with the following:

- Check all that apply:
- | | | |
|----------------------------------------------|----------------------------------------|----------------------------------------|
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart trouble | <input type="checkbox"/> Kyphosis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Back problems | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Lung disease | <input type="checkbox"/> Cancer | <input type="checkbox"/> None of these |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Don't know |
| | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Other _____ |

PAST MEDICAL HISTORY

What surgeries have you had?	Date:
<input type="checkbox"/> Tonsillectomy/Adenoidectomy	1. _____ Date: _____
<input type="checkbox"/> Appendectomy	2. _____ Date: _____
<input type="checkbox"/> Gallbladder	3. _____ Date: _____
<input type="checkbox"/> Hysterectomy	4. _____ Date: _____
<input type="checkbox"/> Diabetic	5. _____ Date: _____
<input type="checkbox"/> Other	6. _____ Date: _____
	7. _____ Date: _____

Allergies (food, medication, ect.)	Over the Counter/Prescription Medications and Dosage
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____
4. _____	4. _____
5. _____	5. _____
6. _____	6. _____
7. _____	7. _____

Habits:

SOCIAL HISTORY

Smoking Do you now or have you ever smoked? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please complete the following: I smoke ___ packs per day and I have smoked for ___ years. OR I did smoke ___ packs per day for ___ years, but I quit smoking ___ years ago. Do you use any smokeless tobacco products? <input type="checkbox"/> Yes <input type="checkbox"/> No	Alcohol Do you drink: Beer? <input type="checkbox"/> Yes <input type="checkbox"/> No Wine? <input type="checkbox"/> Yes <input type="checkbox"/> No "Hard" drinks? <input type="checkbox"/> Yes <input type="checkbox"/> No Frequency of drinking: <input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Daily <input type="checkbox"/> Socially (how often ____) Do you have a history of heavy drinking? <input type="checkbox"/> Yes <input type="checkbox"/> No	Coffee Do you drink coffee? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, how many cups per day? _____ Soft Drinks Do you drink soft drinks? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, how many 12 oz. cans per day? _____
Education Check the highest level completed: <input type="checkbox"/> Grammer School <input type="checkbox"/> High School <input type="checkbox"/> College <input type="checkbox"/> Post-graduate	Drugs Do you use any recreational drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever used needles to inject drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Please list current problems or any other relevant medical or past history: _____

HEALTH HISTORY

(CONFIDENTIAL)

Name: _____ Today's Date: _____

Date of last physical examination: _____

SYMPTOMS (Check symptoms you currently have or have had in the past year.)

General

- Chills
- Depression
- Dizziness
- Fainting
- Fever
- Forgetfulness
- Headache
- Loss of sleep
- Loss of weight
- Nervousness
- Numbness
- Sweats

Gastrointestinal

- Appetite poor
- Bloating
- Bowel changes
- Constipation
- Diarrhea
- Excessive hunger
- Excessive thirst
- Gas
- Hemorrhoids
- Indigestion
- Nausea
- Rectal bleeding
- Stomach pain
- Vomiting
- Vomiting blood

Eye, Ears, Nose, Throat

- Bleeding gums
- Blurred vision
- Crossed eyes
- Difficulty swallowing
- Double vision
- Earache
- Ear discharge
- Hay fever
- Hoarseness
- Loss of hearing
- Nosebleeds
- Persistent cough
- Ringing in ears
- Sinus problems
- Vision-Flashes
- Vision-Halos

Men Only

- Breast lump
- Erection difficulties
- Lump in testicals
- Penis discharge
- Sore on penis
- Other

Women Only

- Abnormal Pap smear
- Bleeding between periods
- Breast lump
- Hot flashes
- Nipple discharge
- Painful intercourse
- Vaginal discharge

Muscle/Joint/Bone

- Arms Hips
- Back Legs
- Feet Neck
- Hands

Cardiovascular

- Chest pain
- High blood pressure
- Low blood pressure
- Poor circulation
- Rapid heart beat
- Swelling of ankles
- Varicose veins

Skin

- Bruise easily
- Hives
- Itching
- Change in moles
- Rash
- Scars
- Sore

Genito-Urinary

- Blood in urine
- Frequent urination
- Lack of bladder control
- Painful urination

Date of last: _____
 Menstrual period _____
 Date of last: _____
 Pap Smear _____
 Have you had a mammogram?
 Yes No
 Are you pregnant?
 Yes No
 Number of children: _____

Conditions (Check conditions you have or have had in the past.)

- | | | | | |
|---------------------------------------------|----------------------------------------------|--------------------------------------------|---------------------------------------------|---------------------------------------------|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Hernia | <input type="checkbox"/> Mumps | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Herpes | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Polio | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Prostate Problem | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Bleeding disorders | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Breast lump | <input type="checkbox"/> Goiter | <input type="checkbox"/> Measles | <input type="checkbox"/> Rheumatic Fever | |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Migraine Headache | <input type="checkbox"/> Scarlet Fever | |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Gout | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Stroke | |

1 NP Inc. dba
Farwell Family Healthcare
P.O. Box 245, 301 Third St.
Farwell, Texas 79325
Phone: 806-481-7000
Fax: 806-481-1006

PATIENT CONSENT AND ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

I understand that as a part of the provision of healthcare services, Farwell Family Healthcare creates and maintains health records and other information describing among other things, my health history, symptoms, examinations and test results, diagnosis, treatment, and any plans for future care of treatment.

I have been provided with a notice of privacy practices that provide a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserve the right to change the notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to request restrictions as to how my health information my be used or disclosed to carry out treatment, payment, or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conduction or arranging for medical review, legal services, and auditing functions, etc.) and that the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me of the purposes of treatment, payment and healthcare operations. I have the right to revoke this consent, in writing, except where disclosures have already been made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records whether written or oral or in electronic format are confidential and cannot be disclosed for any reason outside of treatment, payment and health care operations without my prior written authorization.
2. A photocopy of fax of this consent is as valid as the original.
3. I have the right to request that the use of my protected health information, which is used or disclosed for the purpose of treatment, payment and health care operations, be restricted. I also understand that the practice and I must agree to any restriction in writing that I request on the use and disclosure of my protected health information; and agree to terminate any restriction in writing on the use and disclosure of my protected health information which I have been previously agreed upon.

Patients Name Printed

Date of Birth

Patients Signature (for Guardian of a Minor)

Patients Social Security Number (IDpurposes only)

Witness (optional)

Date

1 NP Inc. dba
FARWELL FAMILY HEALTHCARE

P.O. BOX 245, 301 THIRD ST. SUITE B
FARWELL, TEXAS 79325
PHONE: (806)481-7000
FAX: (806)481-1006

NOTICE TO PATIENTS

This is to inform you that you will be seen and treated by a Nurse Practitioner. A Nurse Practitioner is a skilled health provider who works with physicians to provide needed services, but is not a doctor. Please sign this form if you and/or your children consent to be seen and treated by a nurse practitioner.

Patient Name

Date of Birth

Signature

Date

AVISO DE INFORMACION

Este aviso de informacion es Enfermera Practicante. El Enfermera Practicante son personas que an estudiado y enrenado para poder proporcionar los servicios necesitados, pero no son doctores. Por favor firme este consentimiento si permite que el Enfermera Practicante lo trate a used o asus ninos.

Nombre Del Paciente

Fecha De Nacimiento

Firma

Fecha

1 NP Inc. dba
Farwell Family Healthcare
Consent to Treatment

I (the patient/parent/guardian/legal representative of the patient acting on the patient's behalf) hereby consent to medical treatment, including radiological and laboratory procedures, to be performed by the nurse practitioner and staff of Farwell Family Healthcare. This consent is valid from this date forward.

Release of Information: The Farwell Family Healthcare and/or any nurse practitioner treating the patient may disclose to any person or corporation which is or may be liable under a contract to the clinic and/or physician or to the patient or to a family member of the patient for all or part of the clinic and/or physician or nurse practitioner charges, including, but not limited to clinic or medical service companies, insurance companies, workman's compensation carriers, welfare funds, or the patients employer.

Financial Agreement: The undersigned agrees, whether he signs as agent or patient, that in consideration of the services to be rendered to the patient, he hereby individually obligates himself to pay the account of the clinic in accordance with the regular rates and terms of the clinic. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expenses. All delinquent accounts bear interest at the legal rate.

Medicare and/or Medicaid Certification: The undersigned certifies that he/she has read the foregoing, and is the patient or duly authorized by the patient as patient's general agent to execute the above and accept its terms.

"I assign payment for the unpaid charges for certain medical treatment furnished by the nurse practitioner and staff of the Farwell Family Healthcare and by attending physicians for whom the clinic is authorized to bill. I understand that I am responsible for any health insurance deductibles and coinsurance at the time of services rendered."

"I certify that the information given by me in applying for payment under Title XVIII and /or Title XIX for the Social Security Administration is correct. I authorize any holder of medical or other information about me to release to social Security Administration or its intermediaries or carriers of any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf."

Patients Signature

Date

Witness

Signature

Relationship

If you wish for information to be released and/or discussed with a third party of your choice, please complete the following:

I, _____, authorize Farwell Family Healthcare, Lacey Meeks FNP-BC, and/or Dr. Craig Barker and staff to release information regarding my health and medical treatment to the person(s) listed below.

Name	Relationship to patient	Phone Number

Name	Relationship to patient	Phone Number

Patient Signature	Date

Can appointment notifications be sent by:

e-mail Yes No e-mail address _____
 Text Notifications Yes No
 Voice Notifications Yes No

Can we contact you by cell phone? yes no If yes please enter a cell phone number:
()- -

Can we contact you at work? yes no If yes please enter a work phone number.
()- -

Can we leave a message for you at work, home, or cell phone.

1 NP Inc. dba
Farwell Family Healthcare
301 Third St. Ste. B, P.O. Box 245
Farwell, Texas 79325
PH 806-481-7000
FX 806-481-1006

I, _____, understand that the 1 NP Inc., dba Farwell Family Healthcare does not treat or file claims for Workman's Compensation related treatment.

Please be advised that 1 NP Inc., dba Farwell Family Healthcare has the right to disclose any information regarding your treatment at our facility to an insurance company or your employer that suspect treatment for workman's compensation.

Signature

Date

Print name here

I, _____, (patient name) understand that 1 NP Inc., dba Farwell Family Healthcare does not treat any automobile accident patients.

Please be advised that 1 NP Inc., dba Farwell Family Healthcare reserves the right to refuse patients involved in automobile accidents.

Signature

Date

Printed Name

Farwell Family Healthcare

P: 806-481-7000 | F: 806-481-1006

Lacey Meeks, MSN,ACNP-BC,FNP-BC

*Cancellation/No Show Policy for office appointments/
injections*

***Cancellation/No show policy for office appointments**

We understand that there are times when you may miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Equally, the situation may arise where another patient fails to cancel and we are unable to schedule **you** due to a seemingly full schedule.

If an appointment is not cancelled at least 24 hours in advance, you will be charged a \$25 fee. This will not be covered by your insurance and must be paid prior to further treatment.

Patient Name (printed)

Patient Signature

Date Signed

Date of Birth

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Social Media and Texting

I, _____, understand that any and all medical question need to be addressed at Farwell Family Healthcare and not on social media or through electronic devices.

Signature

Date

Print name here

Medication Refills

I, _____, understand that I need to call my pharmacy for any and all medication refills. Once Farwell Family Healthcare receives the refill request, please give Farwell Family Healthcare 24-48 business hours to respond.

Thank you.