Garden Street Medical Group
Brittany Marshall, MD
Grant Marshall, MD

ADULT PATIENT INTAKE FORM

Phone: 321-269-9612
Fax: 321-269-8433
www.missionfamilymed.com

Welcome to Garden Street Medical Group!

We are pleased to serve your health care needs and those of your family.
In order to assist our providers and staff, please complete this information to the best of your ability.

Patient Name: _____ Sex: M F Date of Birth: ___/____/____

Address: _____
Street City/Town State Zip Code

Home Phone:_____Cell Phone:_____Work Phone:_____Ext.:_____

Emergency Contact:_____(___)_____
Name Phone Number

Insurance Carrier: _____ Policy Holder Name: _____
Policy Number:_____Your relation to Policy Holder_____ Policy Holder SS#_____

I agree to allow Garden Street Medical Group to send a bill for treatment(s) to my insurance carrier:

Patient signature: _____ **Date**___/____/_____

Former Primary Care Provider: _____(____)_____
Name Address Phone number

Please list below any specialists you see/have seen, and contact information if possible:

_____

_____

ADVANCE DIRECTIVES

Do you have a living will? Yes No
Do you have a health care proxy? Yes No Name/Phone# _____

Have you designated someone "Power of Attorney?" Yes No Name/Phone# _____

Have you issued an order indicating "Do Not Resuscitate" (DNR) Yes No
Please give your provider any documentation you have available regarding the above directives.

PAST MEDICAL HISTORY

Check one for each box....Yes or No

Condition	**Y**	**N**	***Condition***	**Y**	**N**
Seasonal Allergies			Shingles		
Anemia			Thyroid Disease		
Osteoporosis			High Cholesterol		
Arthritis			Kidney Problems		
Migraines			Liver Disease		
Blood Transfusion			Hemorrhoids		
Cancer(type)_____			Hernia		
Cataracts			Mental Illness		
CHF/Heart Failure			ADHD		
Heart Murmur			Anxiety		
Heart Attack year:___			Depression		
High Blood Pressure			Nerve/MuscleDisease		
Blood Clot			Multiple Sclerosis		
Bleeding Disorder			Parkinson's		
COPD/Emphysema			Seizure Disorder		
Tuberculosis			HIV/AIDS		
Meningitis			Sexually Transmitted Disease		

List others below:

_____

_____

_____

Patient Name_____ **Date of Birth** ___/____/_____

Please provide any additional details regarding those condition(s) where you marked "yes":

_____

_____

_____

HEALTH MAINTENANCE HISTORY (Please indicate date of last exam/test)

	Date		Date		Date
Complete Physical Exam		Colonoscopy		Gardasil (HPV) Vaccine	
Pap Smear		Eye Exam		Shingles Vaccine	
Mammogram		Tetanus		EKG	
Bone Density Scan		Pneumovax		Chest X-ray	
PSA test (prostate blood test)		Influenza		Dental Exam	
Rectal Exam		TB test			

Medication Allergies (include reaction):

_____

_____

Medications (Includes birth control, over the counter, vitamins, supplements, and herbal remedies)

Preferred Pharmacy: _____

Name Dose Frequency Reason For Use

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Surgeries: (include year)

_____

_____

Patient Name_____ **Date of Birth** ___/_____/_____

Hospitalizations

Year_____ Reason_____ Facility_____

_____

_____

_____

Obstetric/Gynecologic History For Women

Age of first menstrual period _____ Last menstrual period _____ Period Frequency_____ Age of menopause _____

Total Number of Pregnancies _____ Number of Living children _____

Full Term ____ Premature ____ Miscarriages ____ Abortions _____

Personal Background

Gender Identity: _____ Sexual Orientation: _____ Ethnicity:_____

Marital Status: Single ____ Married ____ Divorced ____ Widowed ____ Separated ____

Occupation:_____ Employer:_____

Unemployed ____ Retired_____ Disabled _____ Cause of Disability: _____

Tobacco Use: Yes __ No__ Former ___ Type_____ #Years _____ # Packs/Day____ # Year Quit_____

Alcohol Use: Yes __ No__ Former ___ Type _____ Amount_____ Frequency_____ Abuse Yes/No

Drug Use: Yes __ No__ Former ___ Type _____ IV Drugs - Yes/No Rehab - Yes/No

Family Medical History:

Disease	Mother	Father	Sister(s)	Brother(s)	Mom's Mom	Mom's Dad	Dad's Dad	Dad's Mom	Other Relative
Alcoholism / Drug abuse									
Alzheimers									
Autoimmune Disease									
Bleeding or Clotting Disorder									
Cancer Breast									
Cancer Colon									
Cancer Ovarian									
Cancer Prostate									
Cancer Other Type									
Coronary Artery Disease (e.g. heart attack, angina)									
Depression / Suicide / Anxiety									
Diabetes									
Genetic Disorder (explain)									
Heart Disease									
High Blood Pressure - Hypertension									
High Cholesterol									
Hypothyroidism / Thyroid Disease									
Kidney Disease									
Kidney Stones									
Osteoporsis									
Other (list below)									
If deceased, put age and cuase									

Review of Systems: In the last two days have you experienced any of the following:

General
- Fever
- Chills
- Fatigue
- Unexplained Weight Loss

HEENT
- Double Vision
- Eye Drainage
- Difficulty Swallowing
- Hearing Loss
- Vision Loss

Cardiovascular
- Chest Pain
- Heart Racing/Palpitations

Respiratory
- Cough
- Wheezing
- Shortness of Breath

Gastrointestinal
- Abdominal Pain
- Nausea/Vomiting
- Diarrhea/Constipation
- Blood in Stool

Genitourinary
- Burning with urination
- Blood in urine
- Vaginal/Penile Discharge
- Abnormal Vaginal Bleeding

Musculoskeletal
- Difficulty Walking
- Frequent Falls
- Joint Swelling
- Joint Redness

Neurological
- Loss of Consciousness
- Headache
- Weakness in Arms or Legs
- Numbness
- Dizziness

Skin
- Rash
- Wound

Psychiatric
- Depression
- Anxious Mood
- Suicidal Thoughts or Plans
- Thoughts or Plans to Hurt Others

Dr. Mark Storey
Dr. B. Grant Marshall
Dr. M. Brittany Bales Marshall

1785 Garden Street
Titusville, Florida 32796

Test Results and Authorization Form
Patient authorization for use and disclosure of Protected Health Information (PHI)

I authorize Garden Street Medical Staff to leave a message regarding my medical care at the following telephone number(s):

Telephone_____

Telephone_____

I authorize Garden Street Medical Staff to discuss or leave a message regarding my medical care with the following individual(s):

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

_____
Patient Name

_____
Date of Birth

_____
Signature

_____
Signature Parent/Guardian

Garden Street Medical Group, LLC

Mark S. Storey, M.D.
B. Grant Marshall, M.D.
M. Brittany Bales Marshall, M.D.
1785 Garden Street
Titusville, FL 32796

ACKOWLEDEGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received and had an opportunity to ask questions concerning the above named Practices Notice of Privacy Practices.

Date:_____

_____

Patient or Patient's Representative Signature

_____

Print Patient's Name

If signed by Representative, state name of

Representative:_____

Relationship to Patient:_____