C. Thomas Bevill, MD
B. Craig Depew, MD

THE FAMILY MEDICINE CLINIC
12 Medical Drive
P.O. Box 200185
Cartersville, GA 30120
Phone: 770-386-1000
Fax: 770-386-9165

Michael Williams, MD
Sashikumar Tharmarajah, MD

DATE:_____

SEX: ☐Female ☐Male

NAME:_____BIRTH DATE____/____/____AGE_____RACE_____

MARITAL STATUS: ☐Married ☐Single ☐Divorced ☐Widowed ☐Separated

STREET ADDRESS: _____CITY: _____STATE _____ZIP CODE: _____

MAILING ADDRESS: _____CITY: _____STATE _____ZIP CODE: _____

DAYTIME PHONE #: _____EVENING PHONE #: _____CELL #: _____

IN ORDER TO HELP US BETTER UNDERSTAND YOUR HEALTH NEEDS, PLEASE ANSWER THE FOLLOWING QUESTIONS

Do you have any chronic health problems? If so, please list:
1:_____ 2:_____ 3:_____ 4:_____
5:_____ 6:_____ 7:_____ 8:_____

Have you had any operations? If so, please list:
1:_____ 2:_____ 3:_____ 4:_____
5:_____ 6:_____ 7:_____ 8:_____

Do you take any medications, if so, please list:
1:_____ 2:_____ 3:_____ 4:_____
5:_____ 6:_____ 7:_____ 8:_____

DO YOU HAVE ANY ALLERGIES TO MEDICINE OR FOOD?
1:_____ 2:_____ 3:_____ 4:_____

Do you smoke: ☐No ☐Yes How much? _____ Do you drink? ☐No ☐ Yes How much? _____

Do any of the following run in your family? ☐Heart attack ☐Diabetes ☐Cancer ☐ Other_____

Do you have other specialist doctors or health care providers? Please list them as well as condition they are treating:

1: _____ 2: _____

3: _____ 4: _____

PLEASE CHECK THE FOLLOWING IF APPLICABLE: _____# of pregnancies _____# of children

☐Allergies
☐Angina
☐Anxiety
☐Arthritis
☐Asthma
☐Back problems
☐Blood in stool
☐BPH
☐Broken bones
☐Change in bowel movements
☐Constipation
☐Dental problems
☐Depression
☐Diarrhea
☐Dizziness
☐Difficulty swallowing
☐Emphysema
☐Eye problems
☐Gallbladder disease
☐Gout
☐Hearing problems
☐Heart attack
☐Heartburn/indigestion
☐Heart failure
☐Hiatal hernia
☐High blood pressure
☐High cholesterol
☐Irregular heartbeat
☐Kidney disease
☐Kidney stones
☐Liver disease
☐Menopause
☐Menstrual irregularities
☐Migraines
☐Pancreas disease
☐Peripheral vascular disease
☐Prostate infection
☐Recurrent headaches
☐Recurrent sinusitis
☐Reflux
☐Repetitive motion injuries
☐Sexual transmitted
☐Skin cancer
☐Thyroid disease
☐Ulcers
☐Urinary tract infections
☐Weight loss disease
☐Other lung disease
☐Other vascular problems

Please list other health problems: 1)_____ 2)_____ 3)_____ 4)_____

5)_____ 6)_____ 7)_____