Today's Date: ____________________

Kristin Harmon, MD
2623 Centennial Blvd, Suite 204
Tallahassee, FL 32308

Patient Name: ________________________________ Date of Birth: _____________________

STAFF TO COMPLETE WT: __________ T: __________ HR: __________ BP: __________

PsO2: _________ BBG: __________ A1C: _________

Your Pain Level Today (circle one) **0 1 2 3 4 5 6 7 8 9 10**

Chief Complaint: ____

____

Current Primary Care Physician: _______________________

Referring Physician if different: ____________________________

Current Pharmacy (Local): ______________________________

Current Pharmacy (Mail): _________________________

SYMPTOMS TODAY

◯ General Good Health	◯ Nausea	◯ Weakness
◯ Weight Gain	◯ Vomiting	◯ Numbness
◯ Weight Loss	◯ Constipation	◯ Burning
◯ Excessive Fatigue	◯ Diarrhea	◯ Pins & Needles
◯ Excessive Thirst	◯ Blood in Stool	◯ Tremor
◯ Blurred Vision	◯ Abdominal Pain/Cramping	◯ Headache
◯ Double Vision	◯ Hair Loss	◯ Anxiety
◯ Shortness of Breath	◯ Abnormal Hair Growth	◯ Depression
◯ Cough	◯ Change in Nails	◯ Sleep Disturbances
◯ Palpitations	◯ Excessive Sweating	◯ Frequent Urination
◯ Irregular Heart Rate	◯ Pain in Joints	◯ Nighttime Urination
◯ Chest Pain	◯ Back Pain	◯ How Often/Night
◯ Ankle Swelling	◯ Swelling in Joints	◯ Blood in Urine
◯ Sexual Problems	◯ Recent Fractures	◯ Poor Urine Control
◯ Low Sex Drive		

FOR WOMEN ONLY: Are you still having periods? YES NO

If yes, are they regular? YES NO Length of cycle? _____ days

If no, age of menopause? _____

◯ Estrogen Therapy ◯ Discharge from Breast

Patient Name:________________________ **Patient Date of Birth:**___/___/_____

<u>Personal History: (Check all that apply and briefly explain)</u>

- Diabetes_____________________________________
- Skin Problems: ________________________________
- High Blood Pressure: ___________________________
- Heart Disease: _________________________________
- Arthritis: _____________________________________
- Thyroid Disease: _______________________________
- Cancer:_______________________________________
- Stomach Ulcers:________________________________
- Kidney Disease: _______________________________
- Heartburn: ____________________________________
- Liver Disease: _________________________________
- Anemia: ______________________________________
- Neurologic Disease: _____________________________
- Blood Clots: ___________________________________
- Seizures: _____________________________________
- Other Medical Problems:
  ____
  ____
  ____

<u>Medication History:</u>

Drug Allergies and Reaction:

____
____
____

Current Medications with Dosage and Instructions:

____
____
____
____
____
____
____

<u>Family History:</u>

Type of Disorder:	**Family Relationship:**
- Diabetes: ____________________	____________________________
- Thyroid Disease: _______________	____________________________
- Heart Disease: _____________________	____________________________
- Hypertension: ____________________	____________________________
- Stroke: __________________________	____________________________
- Cancer: _________________________	____________________________
-Cholesterol/ Lipid Disorder: _______________	____________________________
- Osteoporosis: ____________________	____________________________
- Abnormal Calcium: ________________	____________________________
- Kidney Stones: ___________________	____________________________
- Pituitary or Adrenal Tumor: _______________	____________________________
- Other: _________________________________	____________________________

Mother Living:__ Yes ___ No Medical Problems: ______________________________

Father Living: __ Yes __ No Medical Problems: ______________________________

Past Surgical History:

____
____
____

Smoking:
____ Yes ____No _____________Quit/ Date you stopped
______ Number of Cigarettes per day _______Smokeless Tobacco/ Vape

Alcohol:
___ Yes ___ No _______________Quit/ Date you stopped
______ Number of drinks per day ___________________Type of Alcohol

Substance Abuse:
___ Yes ___No Describe: ____

Marital Status:______________________________

Exercise:
___ Yes ___No _____Number of minutes per day, ____Days per week

Current Occupation:_________________________________

Number of servings of Caffeine a day: ________ **Type of Caffeine:**_____________

Describe your diet:____

Children:____

For Patients with Diabetes Only

- Duration of Diabetes:______________________________________
- Age of onset:_________
- Current Treatment Regimen:
  - Oral Agents:_____________________________________
  - Insulin:____
- Do you have a Glucose Meter or CGM: ___ Yes ___No Type: ___________________________
- How often do you check glucoses: ____
- Any complications with your diabetes (check all that apply):

___ Eye Problems ____ Angioplasty (Date:___________)
___ Kidney Problems ____ Foot Ulcer (Date:___________)
___ Nerve Damage ____ Bypass Surgery (Date:_________)
___ Heart Attack

- Date of Most Recent Stress Test: __________
- Date of Most Recent Eye Exam: ___________

Kristin Harmon, MD
2623 Centennial Blvd, Suite 204
Tallahassee, FL 32308
850-702-5007 p
850-219-1059 f

PATIENT COMMUNICATION INSTRUCTIONS

Date of Birth: ________________

Name: ____

Address: ____

COMMUNICATION METHODS:

1. Cell Home Work Email Text ____________________________ Details No Details
2. Cell Home Work Email Text ____________________________ Details No Details
3. Cell Home Work Email Text ____________________________ Details No Details
4. Cell Home Work Email Text ____________________________ Details No Details
5. Cell Home Work Email Text ____________________________ Details No Details

**Email communication will require a Web Portal account

COMMUNICATION AUTHORIZATION:

Authorized (circle one) YES NO Name: ____________________ Relation: __________

Authorized (circle one) YES NO Name: ____________________ Relation: __________

Authorized (circle one) YES NO Name: ____________________ Relation: __________

Authorized (circle one) YES NO Name: ____________________ Relation: __________

Authorized (circle one) YES NO Name: ____________________ Relation: __________

EMERGENCY CONTACT INFORMATION:

Name: ____________________ Relationship: ______________ Phone: _______________

You may get a copy of our Notice of Privacy Practices at any time.

This authorization will expire on: __________
(if no date is specified, it will expire upon your completion of a new/replacement form)

____ _______________
Signature of patient or legal guardian Date

OFFICE INFORMATION – Kristin Harmon, MD

APPOINTMENT CANCELLATIONS/NO SHOWS:

- We ask for 24 hour notice for appointment cancellations so that we may have an opportunity to schedule someone from our wait list.
- No Shows and Cancellations that occur less than 24 hours before your appointment time may incur a **$45 fee**. If your appointment is on Monday, this would require you to call us on Friday during business hours to cancel.
- If you have not been able to complete your pre-clinic testing (labs, radiology) the providers usually prefer for you to go ahead and come to your follow-up appointment anyway. Results can be shared via phone or portal after the appointment if needed.

LATE POLICY:

- We ask that patients arrive 15 minutes prior to their appointment time. Ideally, this allows for check in time, demographics verification and intake by the clinical staff so that each patient may start their appointment as close to their appointment time as possible.
- If you arrive more than 15 minutes past your appointment time we will make every effort to work you back into that day's schedule, but we may be forced to reschedule you to another date/time depending on patient load for that day.

PATIENT PORTAL:

- We recommend that all patients sign up for the patient portal at www.tallahasseeprimarycare.com
- This allows you to see your appointment schedule and test results (especially when performed at the TPCA facility) and allows for easier communication with staff via messaging.

REFILL REQUESTS:

- Please contact your pharmacy first for any refill requests.
- It may take up to 72 hours for your refill request to be processed, especially if it is a controlled medication.

MEDICATIONS:

- If actively followed in this clinic, you will need to have follow-up appointments & lab work on a regular basis. This timeframe is established by the provider based on your diagnosis, symptoms, and medications in order to help you in the safest, most effective way possible. Please understand that we may not be able to fill your medications if you have not been seen – This is for your safety.

MD/NP/PA:

- My practice uses a variety of professional healthcare providers in order to provide patients with the best and most timely care. Some of these providers include (but are not limited to): Endocrinologist (MD), advanced registered nurse practitioner (ARNP), physician's assistant (PA), certified diabetes educator (CDE), registered nurse (RN), licensed practical nurses (LPN), and certified medical assistants (CMA/RMA). While all of these individuals may be involved in your care, patient care is always overseen by a medical doctor. These individuals work together as a team to improve and provide comprehensive patient care. If you join this practice, your appointment may be with an ARNP or PA and not with the MD, but all care is collaborative even if you are not physically seeing the MD that day. If this type of practice does not work for you, then unfortunately we will be unable to meet your needs

Patient Signature: ______________________________ **Today's Date:** ______________

Patient Name (Print): ______________________________ **Date of Birth:** ______________