Blair Family Medicine, P.A.

Name: _____
First Middle Last

Mailing Address: _____
Street City Zip

Primary Phone: _____ Secondary Phone: _____

Date of Birth: _____ □ Male □ Female SSN: _____

Emergency Contact Name: _____ Phone: _____

Marital Status:
□ Single
□ Married
□ Partner
□ Divorced
□ Separated
□ Widowed

Race:
□ American Indian or Alaska Native
□ Asian
□ Native Hawaiian
□ Black or African American
□ White
□ Hispanic
□ Other Pacific Islander
□ Other Race

Ethnicity:
□ Hispanic or Latino
□ Not Hispanic or Latino

Language:
□ English
□ Spanish
□ Other

Preferred Pharmacy: _____ City: _____

Previous Physician(s): _____

□ I do not have insurance.
□ I have insurance. _____ _____ _____
Insurance Company Group ID Number

Responsible Party: _____ Relationship: _____

DOB: _____

Insurance Authorization and Assignment:

I authorize Blair Family Medicine, P.A. to release to my insurance company and/or their agents any information necessary to determine benefits payable or related services. I authorize the payment of medical benefits to Blair Family Medicine, P.A. **I understand that I am ultimately responsible for all services whether covered by insurance or not.** I also authorize my physician, based on his/her discretion, to access my chart for utilization management review.

_____ _____
Signature Date

Blair Family Medicine, P.A. **Name:** _____

Main reason for today's visit: _____

List all current medications, including any over-the-counter medications or supplements.

☐ I do not take any medications.

Name of Medication	Dosage	Times per Day

Last tetanus shot: _____ (Date) Last flu shot: _____ (Date) Last pneumonia shot: _____ (Date)

List any drug or food allergies or medicines you cannot take.

□ I have no known drug allergies.
□ I am allergic to latex.

ROS, PMHx, RHx, SHx completed by patient and reviewed by physician _____ (Physician Initials)

Blair Family Medicine, P.A. **Name:** _____

Have you ever had any problems with anesthesia? □ No □ Yes _____
(being put to sleep for surgery) Please describe

Have you ever had a serious injury? □ No □ Yes _____
Please describe

List any of your BLOOD RELATIVES who have a history of any of the following, and provide their relationship to you:

□ Family history unknown	Type	Paternal or Maternal & Relationship
Problems/Complications with Anesthesia		
Heart Problems:		
Hypertension		
Heart Attack		
Stroke		
Lungs		
Bleeding/Clotting Problems		
Diabetes		
Cancer		
Seizures		
Other Major Health Problems		

Current Occupation: _____ □ Disabled □ Retired □ Student

Religion: _____

Tobacco Use: □ Never □ Cigarette □ Cigar □ Pipe □ Chew

Age when started? _____ Average use per day? _____ Age when stopped? _____

Alcohol Use: □ No □ Yes

Types and average number per week? Beer: ___ Wine: ___ Wine Coolers: ___ Mixed/Liquor: ___

Have you ever been dependent on or addicted to any drugs? □ No □ Yes (please discuss with physician)

ROS, FMHx, FHx, SHx completed by patient and reviewed by physician _____
Physician Initials

Blair Family Medicine, P.A. **Name:** _____

Childhood Diseases
- □ Chicken Pox
- □ Measles
- □ Mumps
- □ _____

Ears, Nose, & Throat
- □ Ear Infections
- □ Hearing Loss
- □ Sinus Infections
- □ Sleep Apnea
- □ TMJ Dysfunction
- □ _____

Digestive
- □ Diverticulitis
- □ Hemorrhoids
- □ Hepatitis - Type: A B C
- □ Irritable Bowel Syndrome
- □ Reflux
- □ Gallbladder Disease (stones)
- □ _____

Brain/Nervous System
- □ Alzheimer's/Dementia
- □ Seizures
- □ Multiple Sclerosis
- □ Stroke
- □ Headache
- □ Migraine
- □ _____

Allergies/Immune System
- □ AIDS/HIV
- □ Autoimmune Disorder
- □ Lupus
- □ _____

Cancer **Year**
- □ Breast _____
- □ Colon _____
- □ Lung _____
- □ Prostate _____
- □ Skin _____
- □ _____

Heart
- □ Angina (chest pain)
- □ Heart Attack _____
- □ Hypertension _____
- □ Murmur _____
- □ Mitral Valve Prolapse _____
- □ High Cholesterol
- □ High Triglycerides

Bones/Joints
- □ Arthritis
  Joints afected? _____
  - □ Osteo □ Rheumatoid
- □ Osteoporosis
- □ _____

Mental/Emotional Health
- □ Anxiety Disorder
- □ Bipolar Disorder (type 1 or 2)
- □ Depression
- □ Suicide Attempted
- □ _____

History of any other condition
- □ _____
- □ _____
- □ _____
- □ _____

Congenital (Birth) Problems
- □ Congenital Malformation
- □ Down Syndrome
- □ Prematurity_____
- □ _____

Lungs
- □ Asthma (when diagnosed?)
- □ COPD
- □ Cystic Fibrosis
- □ Tuberculosis
- □ _____

Skin
- □ Rosacea
- □ Acne
- □ Eczema
- □ Psoriasis
- □ _____

Glands/Hormones
- □ Diabetes
  - □ Type I □ Type II
  - □ Insulin Requiring?
  - □ Grave's Disease
  - □ Thyroid Disease
    - □ Hyper □ Hypo

  Please specify when diagnosed.

- □ _____
- □ _____
- □ _____
- □ _____
- □ _____

Indicate any major surgeries you have had.

Eyes	□ Cataract	□ LASIK		□ Other
Ears	□ Ear Tubes			□ Other
Nose	□ Rhinoplasty	□ Septoplasty	□ Sinus	□ Other
Mouth/Neck	□ Tonsil/Adenoid	□ Thyroid		□ Other
Heart	□ Bypass	□ Pacemaker	□ Transplant	□ Other
Lungs/Chest	□ Esophagus	□ Lungs		□ Other
Digestive	□ Hernia	□ Gallbladder	□ Appendectomy	□ Other
Female/Male	□ Prostatectomy	□ C-Section	□ Hysterectomy	□ Other
Health	□ Tubal Ligation	□ Bladder	□ Kidney	□ Other
Other (please describe)				

ROS, FMHx, FHx, SHx completed by patient and reviewed by physician _____

Physician Initials

Blair Family Medicine, P.A. **Name:** _____

Please list the names of any other providers you see regularly or have seen within the past year.

Specialty	Name	City	Phone	Fax
OB/Gyn				
Cardiology				
Neurology				
Orthopedic				
Gastroenterology				
Urology				
Dermatology				