Southeastern Center for Infectious Diseases, P.A.

Philbert J. Ford, MD
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2009 Miccosukee Rd, Suite A ~ Tallahassee, FL 32308

Phone: (850) 942-2299 FAX: (850) 942-0322

PATIENT HISTORY

Today's Date: _____

Name: _____
Last name First Name Middle Initial

Gender: □ Male □ Female Date of Birth: _____

Social Security No.: _____ - _____ - _____ Email address: _____

Home phone: (_____) _____ Cell phone: (_____) _____

Work phone: (_____) _____ Employer: _____

Home address: _____
Street Address Apt#

_____
City State Zip

Marital Status: □ Married □ Single □ Divorced □ Widowed □ Partnership

Emergency Contact: _____ Phone: (_____) _____

Relationship to patient: _____

Preferred pharmacy: _____ Pharmacy phone: (_____) _____

If you have additional family and/or friends that may be calling our office, or whom you wish for us to communicate with on your behalf, please list their names: _____

_____

Primary Care Provider: _____ Phone: (_____) _____

Referring Physician: _____

Primary Insurance Company: _____

Policy ID# _____ Group ID# _____

Policy Holder: _____ Relationship to patient: _____

Secondary Insurance Company: _____

Policy ID# _____ Group ID# _____

*******UPON COMPLETION OF THIS PAPERWORK, PLEASE PROVIDE OUR OFFICE WITH YOUR INSURANCE CARD AND PHOTO IDENTIFICATION**

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Date: _____

Patient Name: _____ DOB: _____

Please complete the entire form – this information is very important to your medical care!

PAST MEDICAL/SOCIAL/FAMILY HISTORY:

• ***Please Circle any Illnesses you have currently, or have had in the past:***

Diabetes
High blood pressure
Emphysema/COPD
Stroke
Joint pain/Arthritis
Chicken Pox/Shingles
HIV/AIDS
Cardiovascular/Heart Disease or Heart surgery
Asthma
Gastric Reflux/GERD
Cold Sores/Genital Herpes
Blood clots (Location in the body: _____)
Pneumonia

•***If you are HIV positive, please circle any conditions below that you have, or have had in the past:***

Candidiasis/yeast - mouth or throat
Cervical Cancer
Cryptococcal meningitis
Herpes infection –throat
Tuberculosis/MAC
Recurrent pneumonia
Progressive multifocal leukoencephalopathy (PML)
Coccidiomycosis
Cytomegalovirus
Herpes meningitis
Histoplasmosis
Lymphoma
Wasting Syndrome
Cryptosporidiosis
Encephalopathy
Herpes pneumonia
Kaposi's Sarcoma
Pneumocystis pneumonia

• ***Surgical History (including Dental/oral surgery), please include year performed:***

_____

_____

_____

• ***Social History and Habits:***

Tobacco use _____ packs per day for _____years
Alcohol use _____drinks per day
Illicit drug use: Name of drug _____
Method: _____
Occupation: _____
Pets? _____

• ***Infectious Disease History:***

Please list any infections you have had that required medical treatment: _____

_____

Have you been exposed to any infectious disease recently? □ Yes □ No

What was it? _____ When was the exposure? _____

Have you traveled anywhere recently? □ Yes □ No

If yes, where? _____

- ***Family Medical History:***

Please check medical problems which run in your family and circle the affected family member:

___	Diabetes	mother	father	sibling	grandmother	grandfather
___	Hypertension	mother	father	sibling	grandmother	grandfather
___	Heart Disease	mother	father	sibling	grandmother	grandfather
___	Stroke	mother	father	sibling	grandmother	grandfather
___	Cancer	mother	father	sibling	grandmother	grandfather
___	Lupus	mother	father	sibling	grandmother	grandfather
___	Kidney Stones	mother	father	sibling	grandmother	grandfather
___	Thyroid Disease	mother	father	sibling	grandmother	grandfather
___	HIV	mother	father	sibling	grandmother	grandfather
___	Other_____	mother	father	sibling	grandmother	grandfather

Please circle the current health status of each family member:

Mother	alive	deceased	unknown
Father	alive	deceased	unknown
Siblings	alive	deceased	unknown
Grandmother (mother side)	alive	deceased	unknown
Grandfather (mother side)	alive	deceased	unknown
Grandmother (father side)	alive	deceased	unknown
Grandfather (father side)	alive	deceased	unknown

<u>For those patients completing paper forms in our office:</u>

Please be advised that completing preliminary health and insurance questionnaires does not establish a physician-patient relationship with this practice. The physicians of Southeastern Center for Infectious Diseases will review your health history to determine whether your condition warrants Infectious Diseases consultation. The physician-patient relationship is not established until such time as you have been physically seen by one of our physicians in our office or in the hospital setting.

<u>For those patients completing online forms through our patient portal:</u>

Please be advised that by using this form to contact our office(s), we are not confirming an appointment nor establishing a physician-patient relationship. As a user of this mode of communication and of our website, you assume all risks with placing confidential information into this portal. This form of communication is not intended for acute, emergency, or life-threatening health conditions. If you believe you are having a health emergency, contact 911 or proceed to your nearest emergency department.

I consent to receive calls/texts from Southeastern Center for Infectious Diseases for my protected healthcare and other services at the phone number(s) above, including my wireless number provided. I understand I may be charged for such calls/texts by my wireless carrier and that such calls/texts may be generated by an automated dialing system.

Signature Date