Infectious Diseases
EXPERT GROUP OF NW FLORIDA

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NEW PATEINT INFORMATION

Patient Name: ______________________________ **Date of Birth**: ____________

Address: ____
Street City State Zip Code

County: ____________ **Country**: ___________ **Social Security Number**: __________

Primary Phone: (___) _________ **Cell #**: (___) ________ **Alternative #**: (___) __________

E-Mail Address_________________ **Marital Status**: (Single) (Married) (Divorced) (Widow)

Sex: (Male) (Female) **Race**: (White) (African American) (American Indian) (Asian) Other______

Occupation: ________ **Previous Occupations**: _________**Occupation of Spouse**: ______

Birthplace: ___________ **List all States or Countries you have lived in**: ____________

Have you traveled outside the USA in the last year? (Yes) (No). **If yes, where**: __________

Who is your Primary Care Physician? ___________________________________
Physician name Phone number

Were you referred to the office? (Yes) (No) **If so, by whom?** ____________________

Pharmacy of Choice: ___________________ **Hospital of Choice**: _______________

Emergency Contact Person: ____
Name Relationship to patient phone number

Education: Grade school: (Yes) (No) HS Diploma: (Yes) (No) College (Yes) (No) Degree____

Reason for today's appointment? ____

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INSURANCE INFORMATION

Primary Insurance Name: ____________________

Subscribers Name: ____________________ Subscribers Date of Birth: ____________________

Relationship to Patient: (self) (spouse) (child) (parent) other: ____________________

Social Security Number of Subscriber: ____________________

Policy/ID Number: ____________________ Group Number: ____________________

Effective Date: ____________________ Does your insurance require an authorization? (Yes) (No)

Secondary Insurance Name: ____________________

Subscribers Name: ____________________ Subscribers Date of Birth: ____________________

Relationship to Patient: (self) (spouse) (child) (parent) other: ____________________

Social Security Number of Subscriber: ____________________

Policy/ID Number: ____________________ Group Number: ____________________

Effective Date: ____________________ Does your insurance require an authorization? (Yes) (No)

GUARANTOR'S INFORMATION

Is Patient a Minor? (Yes) (No) Relationship to patient? ____________________

Guarantor's Name: ____________________ Guarantor's Date of Birth: ____________________

Address if different from patient: ____________________

Guarantor's Social Security Number: ____________________ E-Mail number: ____________________

Phone Number: ____________________ Cell Number: ____________________

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PERSONAL HISTORY

(Please check all that apply)

( ) Measles or German measles
( ) Scarlet Fever
( ) Blindness (even temporary)
( ) Pneumonia or Pleurisy
( ) Influenza or Flu
( ) Heart Attack
( ) Rheumatic Fever or Heart Murmur
( ) High Cholesterol
( ) Hepatitis
( ) Diverticulosis
( ) Gonorrhea or Syphilis
( ) Neuritis or neuralgia
( ) Poisoning (food, drug, chemicals)
( ) Nervous Breakdown
( ) Frequent Infections
( ) Any other Diseases
( ) Chickenpox or Mumps
( ) Migraine Headaches
( ) Seizures or Epilepsy
( ) Tuberculosis (TB)
( ) Hay fever
( ) Angina
( ) High Blood Pressure
( ) Diabetes
( ) Gallbladder Disease
( ) Kidney/Urinary Tract Infections
( ) Arthritis or Rheumatism
( ) Anemia
( ) Thyroid Disease or Goiter
( ) Severe Depression
( ) Frequent Sore throat
( ) Whooping Cough
( ) Stroke or Paralysis
( ) Meningitis or Polio
( ) Asthma
( ) Hives or Eczema
( ) Heart Failure
( ) Low Blood Pressure
( ) Ulcer
( ) Hiatus Hernia
( ) Venereal Disease
( ) Bursitis, Sciatica
( ) Unusual Bleeding
( ) Unusual Bruising
( ) X-ray Therapy
( ) Radiation

Have you ever had a Skin Test for (TB) Tuberculosis? (Yes) (No) When? ____________________

Have you ever been immunized for?

Diphtheria..........................	(Yes)	(No)	When? ______________________
Tetanus..............................	(Yes)	(No)	When? ______________________
Polio..................................	(Yes)	(No)	When? ______________________
German measles..................	(Yes)	(No)	When? ______________________
Pneumonia..........................	(Yes)	(No)	When? ______________________
Influenza............................	(Yes)	(No)	When? ______________________
Measles..............................	(Yes)	(No)	When? ______________________
Whooping Cough..................	(Yes)	(No)	When? ______________________

Have you ever had any of the listed below INJURIES?

( ) Broken Bones
( ) Concussion or head injury
( ) Sprains or Dislocations
( ) Ever been knocked out
( ) Lacerations
( ) Whiplash

Have you ever had any Transfusions? ( ) Blood ( ) Plasma **If so, when?** ____________________

Please list your WEIGHT: ______________ what was your weight one year ago? __________________

What was your maximum weight? ______________ what was the year? __________________

What is your HEIGHT? ___________feet and ___________inches.

THIS BOX IS FOR **WOMEN ONLY**

Age at onset of menstruation? ____________ Date of last period? ____________________

Is it possible you may be pregnant? (Yes) (No)

How many days does your menstrual cycle last? _________

Is your menstrual cycle: ( ) regular ( ) irregular

Is your menstrual cycle flow usually: ( ) Heavy ( ) Medium ( ) Light

Do you have cramp usually? (Yes) (No) if yes, are they: ( ) Mild ( ) Severe

How many pregnancies have you had? ( ) none ( ) one ( ) two ( ) three ( ) other ___________

Live Births? ________ Stillbirths? ________ Premature Births? ________

Cesarean Sections? ________ Miscarriages? ________ Complications? (Yes) (No)

Do you have any known allergies? (Yes) (No)
If so, please list____

Do you have any of the following habits?

(Yes) (No)... Sleep well?
(Yes) (No)... Use alcoholic beverages?
Every Day.... (Yes) (No)
(Yes) (No)... Smoke?
How much? __________________________
(Yes) (No)... Exercise?
(Yes) (No)... is your diet well balanced?

HOSPITALIZATIONS

Have you had any hospitalizations that did not include a surgery? (Yes) (No)

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HOSPITALIZATIONS CONTINUED

Please list all Hospitalizations:

Hospital	Date/Year	Reason

( ) Please use back side of paper to list more

Please list all Surgical Procedures:

Hospital	Date/Year	Surgery	Complications

( ) please use back side of paper to list more

MEDICATIONS

Please list all current medications that you are on:
(Please include over the counter (pain relief, vitamins, herbs), IV antibiotics and all other prescribed medications)

Name of Medication	Strength (example 4mg)	How many times a day taken

( ) please use back side of paper to list more

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FAMILY HISTORY

Name of Disease	Father	Mother	Spouse	Sibling	Child
Cancer					
High Blood Pressure					
Suicide					
Tuberculosis					
Stroke					
Birth Defects					
Diabetes					
Epilepsy					
Thyroid Disease					
Heart Trouble					
Mental Illness					
Alcoholism					
Other:					
Other:					
Other:					

Are there any other medical concerns you feel Dr. Ephtimios should know? (Yes) (No)
If so, please address:

____

____

____

By signing below, I believe the above information to be true to the best of my ability.

____ / /
Patient/Guarantor's Signature **Date**

____
Please Print Name