Southeastern Center for Infectious Diseases, P.A.
Philbert J. Ford, M.D. Tameka Funny, M.D. Brenda Broger, ARNP Mike Supplice, ARNP

2009 Miccosukee Rd • 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	Cardiovascular/Heart Disease or Heart surgery
High blood pressure	Asthma
Emphysema/COPD	Gastric Reflux/GERD
HIV/AIDS	Stroke
Joint pain/Arthritis	Chronic Back Pain
Chicken Pox/Shingles	Pneumonia
Cold Sores/Genital Herpes	Blood clots (Location in the body: ________________________)

• *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 list any medical problems which run in your family and identify affected family member:

____

____