BLOUNT Medical Group | Family Medicine, Oasis Skin Care, Weight Management

PLEASE FILL OUT THIS FORM COMPLETELY: Your answers will help us understand your medical concerns and conditions better

Demographic Information (patient information):

Patient Name: _____ DOB: _____ Age: _____

Address: _____ City/St/Zip: _____

Home Phone: _____ Cell Phone: _____ Other: _____

Preferred Number to Call (please circle) : Home Cell Other

Gender: ( ) Male ( ) Female Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Widowed

SSN: ____-___-_____ Email Address: _____

____ Please check here if you would like to receive monthly product specials for Oasis Skin Care via email.

Language if other than English: _____ Race: _____ Ethnicity: _____

Occupation: _____ ( ) Unemployed ( ) Disabled

Place of Employment: _____

Whom may we thank for referring you? _____

Emergency Contact Name: _____ Phone: _____

Reason for Today's Visit: _____

_____

_____

Current Symptoms: _____

_____

_____

Do you need any medications refilled at this visit? If so, please list: _____

_____

_____

_____ (Initial) I am fully aware I may be seen and consent to treatment by Dr Calvin Blount or his State Licensed Nurse Practitioner or Physician Assistant at any time while I am a patient of Calvin Blount Jr. M.D. PA.

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Allergies - Please list all allergies including medications (include latex/iodine/tape, etc)

Allergen	Type of Reaction you experience

Current Medications - Please list all current prescribed and over-the-counter medications

Name of Medication	Dose	Frequency

Patient Medical History - Please circle 'yes' if you have ever been diagnosed with the conditions listed below

AIDS/HIV	yes/no	High Blood Pressure	yes/no
Allergies	yes/no	Hepatitis	yes/no
Anemia	yes/no	Kidney Disease	yes/no
Arthritis	yes/no	Liver Disease	yes/no
Bleeding Disorders	yes/no	Lung Disease	yes/no
Bowel Problems	yes/no	Melanoma	yes/no
Cancer History	yes/no	Pacemaker	yes/no
Diabetes	yes/no	Seizures	yes/no
Emphysema	yes/no	Stomach Problems	yes/no
Heart Attack	yes/no	Stroke	yes/no
Heart Disease	yes/no	Thyroid Problems	yes/no

Other: _____

Preventative Care - Please write the most recent date of your preventative care items below

Flu Shot	____ - ____ - ____	Mammogram	____ - ____ - ____
Pneumonia Shot	____ - ____ - ____	Pap Smear	____ - ____ - ____
Tetanus Shot	____ - ____ - ____	Colonoscopy	____ - ____ - ____
Physical	____ - ____ - ____		

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Family Medical History

		Relationship			Relationship
AIDS/HIV	yes/no	_____	High Blood Pressure	yes/no	_____
Allergies	yes/no	_____	Hepatitis	yes/no	_____
Anemia	yes/no	_____	Kidney Disease	yes/no	_____
Arthritis	yes/no	_____	Liver Disease	yes/no	_____
Bleeding Disorders	yes/no	_____	Lung Disease	yes/no	_____
Bowel Problems	yes/no	_____	Melanoma	yes/no	_____
Cancer History	yes/no	_____	Pacemaker	yes/no	_____
Diabetes	yes/no	_____	Seizures	yes/no	_____
Emphysema	yes/no	_____	Stomach Problems	yes/no	_____
Heart Attack	yes/no	_____	Stroke	yes/no	_____
Heart Disease	yes/no	_____	Thyroid Problems	yes/no	_____

Other: _____

Please explain any 'yes' response above: _____

_____

Patient Surgical History

Type of Operation	Date or age at time of operation

Social History

Tobacco Use: ( ) No ( ) Yes ( ) Former - Year Quit: _____
Type: _____ Amt/day: _____ # Years: _____

Alcohol Use: ( ) No ( ) Yes ( ) Former - Year Quit: _____
Frequency: _____

Illicit Drug Use: ( ) No ( ) Yes ( ) Former - Year Quit: _____
Type: _____ # Years: _____