

Medical History

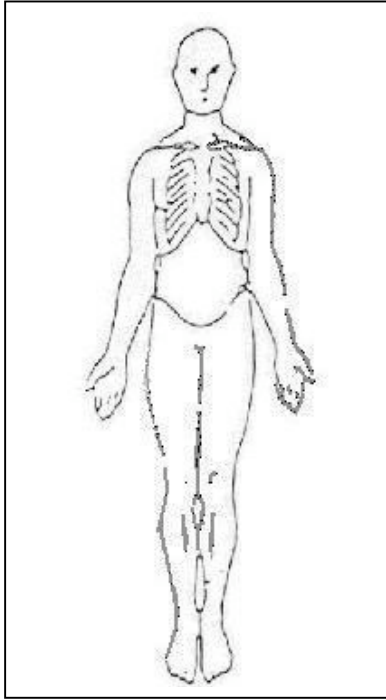
Patients Name _____

Chief Complaint _____

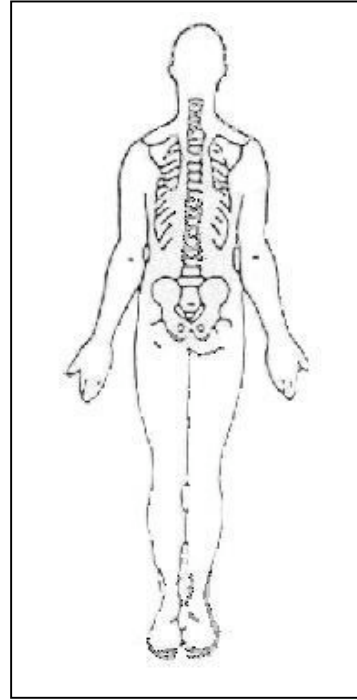
Current Medications _____

Allergies to Medications/Other _____

Do you have any allergies to latex? _____ Exercise (type/how often) _____



Anterior: Shade in Regions of Pain



Posterior: Shade in Regions of Pain

Hospitalizations

Year	Operation/Illness	Hospital	City/State
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First: _____

Second: _____

Family Medical History

Please mark any conditions that have been suffered by a blood relative. Also indicate which relative.

- | | | |
|---|---|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Genetic Diseases | <input type="checkbox"/> Blood Clotting Problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Anemia | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney/Bladder Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gout | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Other _____ |

Personal Medical History

Please place a check next to those conditions that you have had in the past and that are no longer present. Circle those conditions that you are currently experiencing. Also indicate your age at the onset of these conditions

- | | | |
|---|---|--|
| <input type="checkbox"/> Failing Vision | <input type="checkbox"/> Kidney Infections | <input type="checkbox"/> Gall Bladder Problems |
| <input type="checkbox"/> Double/Blurred Vision | <input type="checkbox"/> Pain on Urination | <input type="checkbox"/> Jaundice/Hepatitis |
| <input type="checkbox"/> Eye Pain | <input type="checkbox"/> Poor Control of Urination | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Eye Infections | <input type="checkbox"/> Decreased Force of Urination | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Decreased Hearing | <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Ringing/Buzzing in Ears | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Malaria |
| <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Sexually Transmitted Disease | <input type="checkbox"/> Mononucleosis |
| <input type="checkbox"/> Allergies/Hay Fever | <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Recreational Drug Use |
| <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Alcohol: _____ |
| <input type="checkbox"/> Nose Bleeds | <input type="checkbox"/> Excessive Weight Gain | <input type="checkbox"/> Cigarettes _____ |
| <input type="checkbox"/> Frequent Sore Throats | <input type="checkbox"/> Anemia | Packs per Day _____ |
| <input type="checkbox"/> Prolonged Hoarseness | <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Coffee _____ |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Cancer | Cups per Day _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Other Conditions not listed |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Convulsion/Seizures | above: |
| <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Stroke | _____ |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Tremors | _____ |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Muscle Weakness | _____ |
| <input type="checkbox"/> Short Breath/Exertion | <input type="checkbox"/> Numbness/Tingling Sensation | |
| <input type="checkbox"/> Short Breath/Lying Flat | <input type="checkbox"/> Frequent Headaches | |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Migraine Headaches | #Live Births _____ |
| <input type="checkbox"/> Heart Murmurs | <input type="checkbox"/> Broken Bones: _____ | #Miscarriages _____ |
| <input type="checkbox"/> Palpitations | _____ | Birth Control Type _____ |
| <input type="checkbox"/> Swollen Ankles | <input type="checkbox"/> Arthritis | Age/Onset of Menses _____ |
| <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Osteopenia | <input type="checkbox"/> Regular Period __Y__N |
| <input type="checkbox"/> Leg Pain/Walking | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Light Flow |
| <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Gout | <input type="checkbox"/> Moderate Flow |
| <input type="checkbox"/> Recent Loss of Appetite | <input type="checkbox"/> Cold or Numb Feet | <input type="checkbox"/> Heavy Flow |
| <input type="checkbox"/> Difficulty Swallowing | <input type="checkbox"/> Rashes | Length of Flow _____ |
| <input type="checkbox"/> Heart Burn | <input type="checkbox"/> Psoriasis | Length of Cycle _____ |
| <input type="checkbox"/> Persistent Nausea/Vomiting | <input type="checkbox"/> Eczema | <input type="checkbox"/> Pain/Bleeding with |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Hives | Intercourse __Y__N |
| <input type="checkbox"/> Chronic Abdominal Pain | <input type="checkbox"/> Nervousness | <input type="checkbox"/> PMS (Moderate to Severe) |
| <input type="checkbox"/> Recent Change/Bowel Habits | <input type="checkbox"/> Anxiety Depression | |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Memory Loss | |
| <input type="checkbox"/> Difficulty Sleeping | <input type="checkbox"/> Moodiness | |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Alcoholism | |
| <input type="checkbox"/> Black or Tarry Stool | <input type="checkbox"/> Phobias | |
| <input type="checkbox"/> Red Blood in Stool | <input type="checkbox"/> Mumps | |
| <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Measles | |
| <input type="checkbox"/> Diverticulosis | <input type="checkbox"/> German measles | |
| <input type="checkbox"/> Hernia | <input type="checkbox"/> Chicken Pox | |
| <input type="checkbox"/> Bladder Infections | <input type="checkbox"/> Polio | |

Practice Policies

Dr. Stephen Blood, Dr. Gregory Craddock and Dr. Sasha Rupert

- Emergencies: During non-business hours we will refer you to your local emergency department or primary care physician.
- Cancellations/Missed: **Our doctors do not double book or over book.** Our office has a minimum
- Appointments 24 hour cancellation policy. If this is not possible, please call us as early as possible. Please cancel Monday appointments the previous Friday. Failing to cancel an appointment in advance may result in a normal appointment charge.
- Scheduling: Appointments are scheduled back to back. The doctor does not have the freedom to spend additional time with a patient who arrives late.
- Payment: Payment is requested and expected at the time service is provided. Payment can be made by check, cash or credit card.
- Returned Checks: A fee of \$25.00 will be applied to each returned check.
- Insurance(s): Neither Dr. Blood, Dr. Craddock, nor Dr. Rupert participate with **ANY** insurance carrier, Worker's Compensation or Medicare. Note to TRICARE beneficiaries, we are a "non-authorized" provider. Our office will provide you with a statement that you can submit to your carrier for reimbursement.
- If you are covered by Medicare, TRICARE, or are a retired federal employee, you must notify the front office staff and sign a treatment waiver. **MEDICARE PATIENTS CANNOT SUBMIT TO MEDICARE; TRICARE PATIENTS CANNOT SUBMIT TO TRICARE**, however, if you have a secondary insurance carrier, you may submit to them.
- Authorization: I hereby authorize Stephen Blood, D.O., Gregory Craddock, D.O., or Sasha Rupert D.O., to release to my insurance carrier any information needed to process my insurance claim. I understand that payment for services rendered is due and payable by me regardless of insurance coverage. I also agree to pay for the cost of collections should my account become delinquent (including reasonable attorney fees).
- Consent: Due to health risks involved with accidental needle sticks, in the event of an accidental needle stick incurred by any personnel, I hereby give my permission to have my blood drawn for testing, at no additional cost.
- Privacy Policy My signature below acknowledges that I have received a copy of and read the Patient Privacy Advisory of Osteopathic Family Physicians. (Privacy Policy is previous two pages)

Print Name

Date

Signature

Directions

Osteopathic Family Physicians
1225 Martha Custis Drive, Suite C-7
Alexandria, VA 22302
703 998-6760

From: Richmond; Manassas (66 to 495 to 395); Rockville, MD

- Take 395 toward Washington, D.C.
- Take Exit 7A- Glebe Road South
- At the bottom of the exit ramp, turn right on to South Glebe Road.
- At the next traffic signal, bear right onto West Glebe Road (just past Exxon on Right).
- At the next traffic signal, (Past the Pizza Hut on left) turn right onto Valley Drive.
- Stay towards the right when Valley Drive divides and becomes Martha Custis Dr. (Elementary school on your right).
- Our office is the high rise on the right, Parc East.
- Turn into the main entrance of the building and turn right again.
- We have a separate, ground level entrance with our names on the door.
- There is a handicap ramp located in front of our entrance.

From: D.C.; Rosslyn and other northern areas

- Take 395 South toward Richmond, Virginia
- Take Exit 7- Follow signs for "Glebe Road." The ramp ends at Glebe Road.
- Turn LEFT onto South Glebe Road. Go under the bridges for 395.
- At the second traffic light bear right onto West Glebe Road (just past Exxon on Right).
- At the next traffic signal, (Past the Pizza Hut on left) turn right onto Valley Drive.
- Stay towards the right when Valley Drive divides and becomes Martha Custis Dr. (Elementary school on your right).
- Our office is the high rise on the right, Parc East.
- Turn into the main entrance of the building and turn right again.
- We have a separate, ground level entrance with our names on the door.
- There is a handicap ramp located in front of our entrance.

From Old Town

- Take King Street West into the intersection of King and Quaker Lane.
- Turn right onto Quaker Lane.
- Go approximately 0.9 miles to the end of Quaker Lane.
- At the bottom of the hill and immediately before the large green signs for entrance onto 395, turn right onto Gunston Road.
- At the first stop sign turn left onto Martha Custis Drive.
- Go approximately ¼ mile to the high-rise on the left.
- Our office is on the right side of the building. We have a separate, ground level entrance with our names on the door.
- There is a handicap ramp located in front of our entrance.

