



Blue Cross Blue Shield of Georgia, Inc.
Attn: Medical Underwriting Department-G00301
P. O. Box 4445
Atlanta, GA 30302-9823
Phone: (404) 842- 8000 Fax: (800) 327- 9255

Medical Report For: _____
ID No.: _____
Applicant Name: _____
Date of Birth: _____
Date Sent: 03/11/2009 Return By: _____
Attention: _____

MEDICAL HISTORY
This form must be completed in it's entirety.

Date of Exam: ___/___/___

Please check any of the following as they apply and provide dates, hospitalization, and other pertinent details in the space provided below.

- | | | |
|--------------------------------------------|------------------------------------------------------------------------------------|-----------------------------------------------------------------|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Seizure Disorder | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Pulmonary Disease | <input type="checkbox"/> Alcohol Abuse | <input type="checkbox"/> Counseling |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Drug Abuse | <input type="checkbox"/> Neurological Disorder |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Participation in a drug or alcohol rehabilitation program | <input type="checkbox"/> Other injuries, surgeries or illnesses |
| <input type="checkbox"/> Diabetes Mellitus | | |
| <input type="checkbox"/> HIV | | |

Explanation: _____

Does this patient have any future surgery or hospitalization planned? _____ If so, please explain: _____

Is the patient currently on medication? _____ If yes, indicate name, dosage and reason for medication _____

LABORATORY

List the following laboratory results or attach a copy of the lab report(s);

Cholesterol: Date: _____ Results: TC _____ HDL _____ LDL _____
 Triglycerides: Date: _____ Results: _____
 Blood sugar: Date: _____ Results: _____
 Hematocrit or Hemoglobin Only Date: _____ Results: _____

PHYSICAL EXAMINATION

Height: _____ Weight: _____ Pulse: _____ Respiration: _____ BP: _____

Please indicate (+) if abnormal or (-) if normal as they apply and provide details in space provided.

HEENT _____ Hearing _____ Abdomen _____ Neurological _____ Heart _____
 Sight _____ Skin _____ GU _____ Lungs _____ OB/GYN _____

Explanation of any abnormal findings: _____

Name of Attending Physician (Please Print)	Degree/Licensure	Telephone
Street Address	City State	Zip Code
Signature	Provider Number	Date