MedStar Physician Partners

MPP Specialists at MedStar St Mary's Hospital
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Phone: 301-475-7750 Fax: 301-475-7730

Personal Health History

Date: _____

Name: _____ Birth Date: _____

Referring Physician: _____

Preferred Pharmacy *(name & location)**:*** _____

Any known drug allergies: __ No __Yes If yes, please list the drug and the type of reaction (e.g Penicillin – rash)

1. _____ 2. _____

3. _____ 4. _____

Please check if you have any of the following medical illnesses

	Year Diagnosed		**Year Diagnosed**
Diabetes Mellitus (sugar)		Heart Disease (any)	
Hypertension (high blood pressure)		Gout (high uric acid)	
Hyperlipidemia (high cholesterol)		Kidney Disease	
Thyroid Disease (goiter)		Other:	

Medications

(include birth control pills and over the counter medicines, herbs or vitamins)

Name	**Dose**	**How often**	**Name**	**Dose**	**How often**

Social History

Do you smoke? Yes Never Quit (how long ago? _____) Cigarettes Cigars Pipe

Have you ever smoked: how many year(S) smoking _____ Average # of packs per day _____

Do you drink alcoholic beverages? Yes Never Quit (how long ago? _____)

When was your last physical exam? _____ Chest x-ray_____ EKG_____

Surgical History

Procedure	Year	Procedure	Year

Review of Systems. Check any of these symptoms you have had recently.

	Weight loss or gain		Headaches		Ear Infections
	Sinus problems		Sore throat		Blurry vision
	Facial pain		Nose bleeds		Trouble swallowing
	Sores on genitals		Pain in legs w/walking		Drinking more fluids
	Boils		Chest pains		Shortness of breath @ night
	Heartburn		Abdominal pain		Constipation
	Diarrhea		Dark or bloody stools		Nausea/Vomiting
	Frequent urination		Burning w/urination		Urinating at night
	Discharge or burning		Weakness or Fatigue		Skin rash
	Dry skin		Palpitations		Change in bowel habits
	Shortness of breath w/activity		Pain/burning of feet		Numbness/tingling of feet
	Bothered by hot or cold		Coughing		Coughing up blood
	Lumps		Frequent muscle cramps		Fainting
	Swelling of hands/feet		Dizziness		Trouble w/erections

Family History

List ages and health (Good, Fair, Poor) of relatives listed below. If deceased, list age of death and cause if known.

Father _____ Mother _____

Brothers _____ Sisters_____

Does anyone in the family have any of the following diseases, please indicate who;

Diabetes _____ Hypertension _____

Heart Disease _____ Thyroid Disease _____

Stroke _____ Cancer _____

Kidney Disease _____ Other _____

Women Only:

Age onset of menses (period) _____ Date of last period _____

No. of pregnancies _____ No. of Miscarriages _____ No. of Abortions _____

Hysterectomy? _____ __ If yes, when & what for? _____

If still menstruating, are your periods regular? ___ If yes, average # days between ____ # days flow ____